Chapter II

REVIEW OF LITERATURE

Sexual dysfunction

The term “sexual dysfunction” is referred to impairment either in the desire for sexual gratification or in the ability to achieve it. Sexual dysfunctions are cognitive, affective, and / or behavioural problems that prevent an individual or couple from engaging in and / or enjoying satisfactory intercourse and orgasm (Sadock and Sadock, 2007). It is characterized by repeated inability to participate in sexual relationship of satisfying nature. This may be because of lack of sexual desire, failure of sexual arousal, failure to attain orgasm or failure due to associated pain during sexual act. Sexual dysfunctions can be symptomatic of biological (biogenic) problems or intrapsychic or interpersonal (psychogenic) conflicts or a combination of these factors (Carson, Butcher, Mineka, and Hooley, 2007). Sexual dysfunction may be lifelong or acquired, that is, it can develop after a period of normal functioning. Sexual dysfunction may be generalized or limited to a specific partner or a certain situation.

In the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) (APA, 2000), sexual dysfunction is defined as “a disturbance in the sexual response cycle or as pain with sexual intercourse”. According to International Statistical Classification of Diseases and Related Health Problems (ICD-10) (WHO, 1992), sexual dysfunction is defined as the person’s inability to “participate in a sexual relationship as he or she would wish”. Sarason and Sarason (2005) defined sexual dysfunction as “persistent
impairment of sexual interest or response that causes interpersonal difficulty or personal distress”.

**Classification of sexual dysfunction**
The Diagnostic and Statistical Manual of Mental Disorders (APA, 2000) is classified sexual dysfunctions based on various phases of the sexual response cycle, i.e., (i) desire phase (this phase includes desire to have sexual activity and sexual fantasies); (ii) excitement phase (this phase consists of a subjectively felt sense of sexual pleasure and related physiological changes, for example, penile erections and vaginal lubrication); (iii) orgasm phase (this phase consists of the climax or peaking of sexual pleasure, with release of sexual tension and the rhythmic contraction of the perineal muscles and reproductive organs; in the male there is also ejaculation of seminal fluid, and in the female contraction of the wall of the outer third of the vagina); and (iv) resolution phase (this phase consists of a sense of muscular relaxation and general well-being, in the male this also includes a physiologically refractory period in which further erection and orgasm do not take place immediately. The dysfunctions, linked to these different phases are classified into four categories and are given below (APA, 2000).

I **Sexual desire disorders**

(a) **Hypoactive sexual desire disorder**
Hypoactive sexual desire disorder is characterized by a deficiency or absence of sexual fantasies and desire for sexual activity. The disturbance causes marked distress or interpersonal difficulty. The terms “low libido” and “reduced libido” are also commonly used to refer to this.

(b) **Sexual aversion disorder**
Sexual aversion disorder is characterized by an aversion to and avoidance of, all genital sexual contact with a sexual partner or by masturbation. The
disturbance causes marked distress or interpersonal difficulty. Often the aversion is focused on a particular aspect of sexual experience.

II Sexual arousal disorders

(a) Female sexual arousal disorder
Female sexual arousal disorder is characterized by persistent inability to attain or maintain adequate vaginal lubrication and vaginal expansion in response to sexual excitement.

(b) Male erectile disorder
Male erectile disorder is also called “Erectile dysfunction” and “Impotence”. Male erectile disorder is characterized by persistent or recurrent inability to attain or sustain an adequate penile erection. There is much variability in this, some attain very strong erections without being able to sustain them, some have sustainable erections which are not strong enough for penetration and loss of erection during thrusting is also reported by some. Male erectile disorder can be lifelong or acquired.

III Orgasmic disorders

(a) Female orgasmic disorder
Female orgasmic disorder is also referred to as “inhibited female orgasm”, “anorgasmia” and more rarely “inorgasmia”. Female orgasmic disorder is characterized by recurrent or persistent inhibition of female orgasm, as manifested by the recurrent delay in, or absence of, orgasm after a normal sexual excitement phase.

(b) Male orgasmic disorder
Male orgasmic disorder is characterized by persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase. The essential feature is that male has difficulty in reaching orgasm following a
normal sexual excitement phase, despite adequate stimulation. This condition is also called “inhibited male orgasm” and “retarded ejaculation”. An earlier term, “retarded ejaculation” is problematic, as it focuses on ejaculation rather than orgasm. In some conditions a male can reach an orgasm without discharging any semen. The new term refers specifically to the orgasmic experience.

(c) **Premature ejaculation**

Premature ejaculation is characterized by persistent or recurrent ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes it. Men with this problem regularly ejaculate before or immediately after entering the vagina, thus making any meaningful coital activity impossible.

**IV Sexual pain disorders**

(a) **Dyspareunia**

Dyspareunia is the recurrent or persistent genital pain occurring in either men or women before, during, or after intercourse. The main feature is the genital pain associated with sexual intercourse. Much more common in women than in men, dyspareunia is related to, and often coincides with, vaginismus.

(b) **Vaginismus**

Vaginismus is the persistent involuntary contraction of the muscles surrounding the outer third of the vagina when penetration is attempted. When severe, it makes penetration impossible.

**Revised definitions of female sexual dysfunction**

In 2004, the Second International Consensus of Sexual Medicine is revised the definitions of female sexual dysfunction (Basson, 2005; Frank, Mistretta,
Will, 2008). These revised definitions of female sexual dysfunction are likely
to be included in the DSM V and ICD 11, which is under preparation.

(1)  **Sexual desire/interest disorder**: absent or diminished feelings of
sexual interest or desire, absent sexual thoughts or fantasies, and a
lack of responsive desire; motivations for attempting to become
sexually aroused are scarce or absent; lack of interest is considered to
be beyond the normal decrease experienced with increasing age and
relationship duration.

(2)  **Subjective sexual arousal disorder**: absent or diminished feelings
of sexual arousal from any type of sexual stimulation; however, vагinal lubrication or other signs of physical response occur.

(3)  **Genital sexual arousal disorder**: complaints of impaired genital
sexual arousal, which may include minimal vulval swelling or
vaginal lubrication from any type of sexual stimulation and reduced
sexual sensations from caressing genitalia; however, subjective
sexual excitement occurs with nongenital sexual stimuli.

(4)  **Combined genital and subjective arousal disorder**: absent or
diminished feelings of sexual arousal from any type of sexual stimuli
plus complaints of absent or impaired genital sexual arousal.

(5)  **Persistent genital arousal disorder**: spontaneous, intrusive, and
unwanted genital arousal in the absence of sexual interest and desire;
arousal is unrelieved by orgasms and persists for hours or days

(6)  **Women’s orgasmic disorder**: despite self-report of high sexual
arousal or excitement, there is lack of orgasm, markedly diminished
intensity of orgasmic sensations, or marked delay of orgasm from any
kind of stimulation.
(7) **Dyspareunia:** persistent or recurrent pain with attempted or completed vaginal entry and/or penile vaginal intercourse.

(8) **Vaginismus:** persistent or recurrent difficulties with vaginal entry of a penis, finger, or other object, despite the woman’s expressed desire to participate.

(9) **Sexual aversion disorder:** extreme anxiety or disgust at the anticipation of or attempt at any sexual activity.

Sexual dysfunction may be further defined as lifelong (primary) or acquired (secondary) and as situational (occurs only in certain circumstances or with certain partners) or generalized (occurs in all situations and with all partners). (Crowley, Richardson and Goldmeier, 2006). A lifelong dysfunction is said to exist when the problem has been present since the beginning of sexual functioning, for example, a man who has never had an erection as an adult. In the acquired type, the dysfunction develops only after a period of normal functioning. In the generalized type, the dysfunction occurs in all situations and is not linked to certain types of partners, situations, or stimulation. In the situational type, the dysfunction is limited to certain types of stimulation, situations or partners. For example, a man may have an erectile difficulty when attempting sex with a partner, but not when masturbating.

**Etiology of sexual dysfunction**

Sexual dysfunctions can result from many diverse etiological factors and from innumerable combinations of these factors. A number of potential causative and contributing factors to sexual dysfunction are identified reflecting the complex interplay of physiologic, psychological, emotional, and relational components (Frank, Mistretta, and Will, 2008; Basson, 2005). Major advances
are made in the last few years toward understanding the nature of various forms of male and female sexual dysfunction. The recent findings of the various causative factors of sexual dysfunction are discussed below.

**Sexual desire disorders**

A variety of causative factors are associated with sexual desire disorders. The sexual desire problems are said to be the defensive from the part of patient to protect against his unconscious fears about sex (Sadock and Sadock, 2007). Sigmund Freud conceptualized that low sexual desire as the result of inhibition during the phallic psychosexual phase of development and of unresolved oedipal conflicts (Sadock and Sadock, 2007). Desire disorders are also seen as the result of patient’s maternal transference to sexual partner. Lack of desire can result from chronic stress, preoccupation with life crisis, grief, gender identity conflicts, and aging related psychological issues (Corona, Bandini, Fisher, Elisa, Boddi, Balercia, Sforza, Forti, Mannucci and Magi, 2010; Dennerstein, Hayes, Sand and Lehert, 2009; Rosen, Shifren, Monz, Odom, Russo and Johannes, 2009; Kandeel, Koussa and Swerdloff, 2001). Abstinence of sex for a prolonged period sometimes results in suppression of sexual impulses (Corona, Bandini, Fisher, Elisa, Boddi, Balercia, Sforza, Forti, Mannucci and Magi, 2010).

Relationship problems can cause sexual desire disorders (McCabe and Goldhammer, 2012; Corona, Bandini, Fisher, Elisa, Boddi, Balercia, Sforza, Forti, Mannucci and Magi, 2010; Dennerstein, Hayes, Sand and Lehert, 2009). Carson, Butcher, Mineka and Hooley (2007) reported that loss of desire as an expression of hostility towards the partner or the sign of a deteriorating relationship. Kandeel, Koussa and Swerdloff (2001) reported that marriage related issues and traumatic employment may contribute to diminished self-image and heightened anxiety, leading to male sexual
dysfunction. Empirical studies pointed out that a high correlation of desire complaints with measures of low self-image, negative body image, mood instability, tendency toward worry and anxiety in women (La Rocque and Cioe, 2011; Heiman, 2002). Studies indicated that women with desire disorder had emotional instability, anxiety, neuroticism and self-esteem that is weak or even fragile (Heiman, 2002; Dennerstein, Hayes, Sand and Lehert, 2009). Nobre and Pinto-Gouveia (2008) found that emotional states such as sadness, disillusion, guilt and lack of pleasure and satisfaction are closely associated to hypoactive sexual desire disorders. Cognitive factors also play its role in the causation and perpetuation of desire disorders (Carvalho and Nobre, 2011). Nobre and Pinto-Gouveia (2008) noted that cognitive factors such as, negative automatic thoughts, illogical assumptions and beliefs, incompetence schemas, lack of erotic thoughts and increased attention focus on failure and disengagement thoughts during sexual activity are common in persons with sexual desire disorders. Sexual conservative beliefs seem to be closely related to hypoactive sexual desire disorders.

A substantial number of patients with affective disorder, chronic depression and obsessional personality also develop sexual desire disorder (Kandeel, Koussa and Swerdloff, 2001; Frohlich and Meston, 2002; Lourenco, Azevedo and Gouveia, 2010; Krishna, Avasthi and Grover, 2011). Bancroft, Janssen, Strong, Carnes, Vukadinovic and Long (2003) examined the relation between mood and sexuality in men and found that 42% indicated decreased sexual interest when depressed (compared to 9.4% who indicated increased sexual interest), whereas, when anxious/stressed, 20.6% indicated increased and 28.3% decreased sexual interest. Anxiety and performance anxiety is closely associated with sexual desire disorders. Sexual desire disorders are commonly seen in persons with performance anxiety due to the
fear of sexual failure and the vigilant preoccupation with erection during lovemaking. Similarly anger is also reduces both desire and arousal. Katz and Jardine (1999) tested the relationship between worry as a trait of personality and sexual desire and aversion in a group of male and female students. Results indicated statistically significant correlations between a predisposition to worry and sexual aversive behaviors and low sexual desire. Fatigue can affect sexual functioning; it has direct influence on hypoactive sexual desire disorder (Blazquez, Alegre and Ruiz, 2009). A high frequency of sexual desire disorder is also reported in patients with schizophrenia and other psychotic illness (Lourenco, Azevedo and Gouveia, 2010; Clayton and Balone, 2009; Olfson, Uttaro, Carson and Tafesse, 2005; Aizenberg, Zemishlany, Dorfman-Etrog and Weizman, 1995).

Sexual interest in both men and women depends in part on testosterone. Testosterone deficiency may also lead to hypoactive sexual disorder (Kandeel, Koussa and Swerdloff, 2001; Carson, Butcher, Mineka and Hooley, 2007). Patients with a primary central nerve system (CNS) disease such as partial epilepsy, Parkinsonism, post-stroke and adrenoleukodystrophy may have diminished sexual arousal. A number of pharmacological agents or drugs of addiction could potentially induce sexual desire disorders, including antihypertensives (chlorthalidone, guanadrel, guanethidine, methyldopa, reserpine and spironolactone), psychiatric medications (fluoxetine, barbiturates, clomipramine and fluphenazine), and others (danazol, digoxin, ethinyl estradiol, ketoconazole, methadone, niacin, alcohol, diazepam and marijuana) (Crenshaw and Goldberg, 1996; Finger, Lund and Slagle, 1997).
Sexual arousal disorders
In the case of sexual arousal disorders the role of anxiety, including “performance anxiety” is commonly found to be linked to arousal disorders and indeed some other dysfunctions (Reis and Abdo, 2010; Heiman, 2002; Kantor, Bilker, Glasser and Margolis, 2002). Masters and Johnson (1970) and Kaplan (1987) hypothesized that male erectile disorder is primarily a function of anxiety about sexual performance. A man may be unable to express a sexual impulse because of fear, anger, moral inhibition or anxiety. Bancroft (2009) findings revealed that fear of performance failure is a strong predictor of erectile dysfunction in both gay and heterosexual men. He pointed out that a vicious cycle is developed in erectile dysfunctional people, in which fear of failure is sometimes followed by erectile dysfunction, which is then attributed to internal and stable causes, thereby perpetuating the problem. Even though some of the studies contradicted the models of Masters and Johnson and Kaplan, and suggested a neutral or even a facilitative role of anxiety on both male and female sexual arousal (Nobre and Pinto-Gouveia, 2006a; Nobre and Pinto-Gouveia, 2008). But a conclusive finding on the neutral or even a facilitative role of anxiety on sexual arousal is not emerged.

Barlow (2002) emphasized that cognitive distractions frequently associated with anxiety in dysfunctional people interferes with their sexual arousal. Nobre and Pinto-Gouveia (2008) reported that sexually dysfunctional men and women get distracted by negative thoughts about their performance during the sexual encounter. Their research suggested that this preoccupation with negative thought, rather than anxiety per se, is responsible for inhibiting sexual arousal. Moreover, such self-defeating thoughts not only decrease pleasure but also can increase anxiety if the erection does not happen (Nobre
and Pinto-Gouveia, 2009; Carvalho and Nobre, 2011). A related finding is that men with erectile dysfunction make more internal and stable causal attributions for hypothetical negative sexual events than do men without sexual dysfunction, much as depressed people do for more general hypothetical negative events (Bancroft, Janssen, Strong, Carnes, Vukadinovic and Long, 2003). However, recent researches (Nobre and Pinto-Gouveia, 2009; Carvalho and Nobre, 2011; Gomes and Nobre, 2011) indicated that men and women with sexual dysfunction show cognitive patterns similar to the ones observed in depressive disorders (e.g., incompetence schemas, failure anticipation thoughts, catastrophizing negative consequences, lack of positive thoughts etc.). It is indicative of a cognitive-emotional interference similar to the one observed in depression among sexually dysfunctional patients.

Many studies pointed out the relation between erectile dysfunction and depression (Korfage, Pluijm, Roobol, Dohle, Schröder and Essink-Bot, 2009; Kantor, Bilker, Glasser and Margolis, 2002; Araujo, Durante, Feldman, Goldstein and McKinlay, 1998). Depressed patients with erectile dysfunction had lower libido and are more likely to discontinue treatment for their erectile problem than other patients without depression (Shabsigh, Klein, Seidman, Kaplan, Lehrhoff and Ritter, 1998). In addition, older studies estimated that approximately one-third of all patients with untreated depression have sexual dysfunction (Casper, Redmond, Katz, Schaffer, Davis and Koslow, 1985).

Relationship factors such as marital conflicts, poor communication skills and inadequate conflict resolution styles are said to contribute to erectile disorder (Timm and Keiley, 2011). In an ongoing relationship, male erectile disorder may reflect difficulties between the partners, particularly when a man cannot
communicate his needs or his anger in a direct and constructive way. Persons with a punitive super ego, an inability to trust, feeling of inadequacy or a sense of being undesirable as a partner can contribute to arousal problems (Sadock and Sadock, 2007). In addition, episodes of erectile disorder are reinforcing, with the man becoming increasingly anxious before each sexual encounter (Sadock and Sadock, 2007).

Stresses of various kinds and depressed affect also contribute to sexual dysfunction. Persons with perfectionism and panic disorder may also have male erectile disorder (Kantor, Bilker, Glasser and Margolis, 2002; DiBartolo and Barlow, 1996; Sbrocco, Weisberg, Barlow and Carter, 1997). There is convincing evidence that smoking is a major risk factor for the development of male erectile disorder (Agostini, Netto, Miranda and Figueiredo, 2011). Studies showed that the relative risk of developing arterial atherosclerosis in the penis and subsequent erectile dysfunction is 1.31 for each 10 pack-years smoked and that 86% of smokers have an abnormal penile vascular evaluation. Long-term smoking is also caused ultra structural damage to the corporeal tissue in impotent men. Obesity and alcohol abuse are the associated life style factors associated with erectile disorder (Carson, Butcher, Mineka and Hooley, 2007).

The organic causes of arousal disorders can be grouped into systemic diseases and endocrine, neurological, vascular or local penile disorders. A variety of advanced states of systemic diseases are associated with sexual dysfunctions, including chronic liver disease, renal failure, chronic obstructive pulmonary disease, sleep apnea, cancer and post organ transplantation (Meuleman, 2011; Palmer, 1999). Hepatic cirrhosis and renal failure adversely affect androgen production and/or metabolism (Meuleman, 2011). Diabetes mellitus is recognized as a major cause for male erectile
disorder (Giraldi and Kristensen, 2010; Moreira, Lbo, Diament, Nicolosi and Glasser, 2003). Surveys by various investigators suggested that erectile dysfunction occurs in about 50% of diabetic males, which is twice the incidence in non-diabetic normal males. Moreover, the frequency of erectile dysfunction in diabetics is increased with age, from about 25% at age of 35 to greater than 70% after age of 60 among diabetic patients with autonomic neuropathy. Diabetes is also associated with decreased desire and orgasmic dysfunction in men and women (Moreira, Lbo, Diament, Nicolosi and Glasser, 2003).

Vascular insufficiency is probably the most common cause of organic male sexual dysfunction (Meuleman, 2011; Forstner, Hricak, Kalbhen, Kogan and McAninch, 1995; Meuleman and Diemont, 1995). Atherosclerosis of the large pelvic arteries (common iliac, hypogastric, or pudendal) can lead to inadequate perfusion of the penis. Other examples of large vessel disease are leriche syndrome and penile raynaud’s phenomenon. Erectile disorder secondary to excessive venous leakage is being reported with significant frequency in clinical studies. Endothelial dysfunction is a condition present in many cases of male erectile disorder (Lewis, Fugl-Meyer, Bosch, Fugl-Meyer, Laumann, Lizza and Martin-Morales, 2004).

Male erectile disorder can accompany a variety of acute and chronic central and peripheral nervous system diseases (Kandeel, Koussa and Swerdloff, 2001). Spinal cord injuries deserve a special comment. Loss of erectile or ejaculatory functions in these conditions depends upon the level and extent of the damage. Upper motor neuron lesions diminish the erectile response to psychogenic stimuli but leave the reflexogenic erections intact. The degree of diminution in psychogenic erections is directly related to the extent of the lesion. In contrast, lower motor neuron lesions abolish the reflexogenic
response without altering the psychogenic erections except when the lesion is complete. When the latter occurs, psychogenic erections diminish in about 75% of patients. Penile diseases, such as congenital malformation, Peyronie’s disease, priapism, phimosis and rarely, cold abscess may interfere with erectile function.

Genitourinary trauma that results in rupture of the corpora cavernosa or the encapsulating connective tissue sheaths, formation of traumatic occlusion of multiple arteries, posttraumatic aneurysmal dilatation with arteriovenous fistulae, resection of the cavernosal nerves during pelvic surgery, penile schwannoma, or pelvic irradiation can all be causes for erectile dysfunction (Kandeel, Koussa and Swerdloff, 2001). Such observations suggest that Nitric oxide (NO) pathway abnormalities are involved in the pathogenesis of erectile dysfunction after unilateral cavernosal nerve injury or pelvic radiation in man. Hypogonadism is recently been shown to be associated with decreased Nitric oxide (NO) formation and action in the penis, thus reducing erectile capacity.

Many commonly prescribed pharmacological agents can adversely influence sexual function of the male (Olfsen, Uttaro, Carson and Tafesse, 2005; Kandeel, Koussa and Swerdloff, 2001; Finger, Lund and Slagle, 1997, Crenshaw and Goldberg, 1996). Erectile problems occur in as many as 90 percent of men on certain antidepressant medications (especially the SSRIs). Antihypertensives, anticholinergics, psychotropics and many other agents are common causes for erectile dysfunction (Clayton and Balone, 2009). The percentage of men with complete erectile dysfunction in the Massachusetts Male Aging Study who are taking hypoglycemic agents (26%), antihypertensive drugs (14%), vasodilators (36%), and cardiac drugs (28%) is significantly higher than the 9.6% observed for the sample as a whole.
(Araujo, Durante, Feldman, Goldstein and McKinlay, 1998). Another possibility in the case of antihypertensives is the reduction of blood pressure in the face of penile arterial atherosclerosis (Jensen, Lendorf, Stimpel, Frost, Ibsen and Rosenkilde, 1999). Priapism also results in erectile dysfunction, which can occur as a consequence of disease or as a side effect of certain medications mainly by phenothiazines (e.g., thioridazine and chlorpromazine) or the newer antidepressant trazodone. At present, it is not clear whether drugs of addiction such as alcohol, methadone, and heroin reduce sexual potency by influencing the secretion and metabolism of androgens or by the associated deterioration in the general physical and psychological status of the addict.

Early sexual traumatization, too excessive and distorted socialization about the “evils” of sex, dislike or disgust with current partners’ sexuality are said to be associated with female arousal disorder (Carson, Butcher, Mineka and Hooley, 2007). Other contextual factors reported to reduce arousability in females included concerns about safety (risks of unwanted pregnancy and STDs, for example, or emotional or physical safety), appropriateness or privacy, or simply that the situation is insufficiently erotic, too hurried, or too late in the day. Frequently a woman’s arousal is precluded by nonsexual distractions of daily life, also sometimes by sexual distractions such as, worry about not becoming sufficiently aroused, reaching orgasm, a male partner’s delayed or premature ejaculation or a female partner’s lack of orgasm (Heiman, 2002). Further inhibiting psychological factors include memories of past negative sexual experiences, including those that have been coercive or abusive and expectations of negative outcomes to the sexual experience (e.g., from dyspareunia or partner sexual dysfunction). Cognitive factors, including attitudes and beliefs, both individual and cultural, are also
seen as relevant (Frank, Mistretta and Will, 2008; Basson, 2005). Cognitive factors contributing to the causation of erectile disorder is also applicable to female sexual arousal disorders (Nobre and Pinto-Gouveia, 2006a; Nobre and Pinto-Gouveia, 2008).

Hypertension in women is reported to be associated with decreased lubricative function and orgasmic dysfunction (Lewis, Fugl-Meyer, Bosch, Fugl-Meyer, Laumann, Lizza and Martin-Morales, 2004). Decreased lubrication in women is also significantly associated with being diabetic (Lewis, Fugl-Meyer, Bosch, Fugl-Meyer, Laumann, Lizza and Martin-Morales, 2004; Giraldi and Kristensen, 2010). Hormonal factors are sometimes strongly implicated in sexual arousal disorder where a decrease in estrogen can cause vaginal dryness (Heiman, 2002). Alterations in testosterone, estrogen, prolactin and thyroxin levels have been implicated in female arousal disorders (Basson, 2006). Medications with antihistaminic or anticholinergic properties cause a decrease in vaginal lubrication (Sadock and Sadock, 2007). One recent study found that women with sexual arousal disorder show lower tactile sensitivity than is seen in other women, and the lower the level of tactile sensitivity, the more severe the arousal dysfunction (Frolich and Meston, 2005). One reason why progress toward understanding this disorder is slow is that female sexuality is more complicated than male sexuality.

**Orgasmic disorders**

Numerous psychological factors are associated with orgasmic disorders. In the case of female orgasmic disorder the hostility towards men, feelings of fearful and inadequate in sexual relations, feelings of guilt about sexual impulses and fears of impregnation, rejection by a sex partner and damage to vagina are stated as the causative factors (Sadock and Sadock, 2007). Some women equate orgasm with loss of control or with aggressive, destructive or
violent impulses; their fear of these impulses may be expressed through inhibition of excitement or orgasm (Carson, Butcher, Mineka and Hooley, 2007). Sexual arousal and orgasm, especially in a partner’s presence, necessitates a certain degree of vulnerability, which is impossible for some women who cannot tolerate feelings of loss of control generally and loss of control specifically of their body’s reactions (Basson, 2005). In women, lack of learning to relinquish control has been considered by some authors as an important variable (Nobre and Pinto-Gouveia, 2006a).

Relationship factors also contribute to female orgasmic disorder. A woman may be uncertain whether her partner finds her sexually attractive, and this may lead to anxiety and tension that is said to be interfering with her sexual enjoyment, or she may feel inadequate because she is unable to have an orgasm or does so infrequently. Memories of past negative sexual experiences, including those that have been coercive or abusive, and expectations of negative outcomes to the sexual experience etc can also inhibit the orgasm to occur (Frank, Mistretta and Will, 2008; Basson, 2005).

Cultural expectations and social restrictions on women are also relevant. Many women have grown up to believe that sexual pleasure is not a natural entitlement for so-called decent women (Sadock and Sadock, 2007). Sidi, Midin, Wan-Puteh and Abdullah (2008) points out that female orgasmic disorder is found to be significantly higher in persons with an age group of 45 and above, having lower academic status, married longer, having more children, married to an older husband, and being at menopausal state. They also reveal that women with infrequent sexual intercourse are less likely to be orgasmic. Frequency of sex increases sexual satisfaction (Smith, Lyons, Ferris, Richters, Pitts, Shelley and Simpson, 2010). Studies on the cognitive factors in the orgasmic disorders led to finding that body image beliefs and
automatic thoughts focusing on self-body appearance seem to be strongly associated with orgasmic disorder (La Rocque and Cioe, 2011; Nobre and Pinto-Gouveia, 2006a).

In women, psychiatric disorder is closely associated with orgasmic dysfunction and dyspareunia (Lewis, Fugl-Meyer, Bosch, Fugl-Meyer, Laumann, Lizza and Martin-Morales, 2004). Posttraumatic disorder can be accompanied by sexual dysfunction such as decreased desire, decreased arousal or aversion to sexuality, especially when the trauma is sexual in nature (such as rape or sexual abuse) (Lewis, Fugl-Meyer, Bosch, Fugl-Meyer, Laumann, Lizza and Martin-Morales, 2004; Rellini, Vujanovic and Zvolensky, 2010)

Sadock and Sadock (2007) reported that male orgasmic disorder is seen in men who come from a rigid and puritanical background. Such people perceive sex as sinful, the genitals are dirty, and they may have conscious or unconscious incest wishes and guilt. Sadock and Sadock (2007) pointed out that persons with male orgasmic disorder get distracted easily and the condition can be aggravated by an attention-deficit disorder. A man’s distractibility prevents adequate arousal for climax to take place. The male orgasmic disorder frequently reflects interpersonal difficulties. The disorder is supposed to be man’s way of coping with real or fantasized changes in a relationship, such as plans for pregnancy about which the man is ambivalent, the loss of sexual attraction to the partner, or demands by the partner for greater commitment as expressed by sexual performance (Sadock and Sadock, 2007). In some men, the inability to ejaculate reflects unexpressed hostility towards woman. Low self-esteem and lack of confidence in adolescence, history of unhappy relationships and relationship outside marriage often noticed among persons with male orgasmic disorder
(Robbins-Cherry, Hayter, Wylie and Goldmeier, 2011). The lifelong male orgasmic disorder indicates severe psychopathology in the person.

Male orgasmic disorder is also related to specific physical problems such as multiple sclerosis and to the use of certain medications. The antidepressants that block serotonin reuptake inhibitors which appear to be effective in the treatment of premature ejaculation can delay or prevent orgasm. Absence of emission and/or retrograde ejaculation can be found in men using antihypertensives, monoamine oxidase (MAO) inhibitors, or antipsychotics due to sympatholysis. Delayed ejaculation and/or orgasmic dysfunction may occur with selective serotonin reuptake inhibitors (SSRI) usage due to serotonergic agonist effects. Serotonergic drugs significantly increases (by at least ten-fold) the risk for mild to moderate forms of delayed ejaculation, which, however is also coupled to other relational (impaired partner's climax, patient's hypoactive sexual desire) or intra-psychic (stress at work) factors. Some organic pathological conditions (such as psychiatric disorders and hypogonadism) are also associated to Mild and moderate forms of delayed ejaculation (Corona, Mannucci, Petrone, Fisher, Balercia, De Scisciolo, Pizzocaro, Giommi, Chiarini, Forti and Maggi, 2005). Tricyclic antidepressants can cause painful ejaculation in some patients.

Premature ejaculation is most likely after a lengthy abstinence (Carson, Butcher, Mineka and Hooley, 2007). Premature ejaculation is found to be associated with anxiety in many studies (Carson, Butcher, Mineka and Hooley, 2007). Difficulty in ejaculatory control can be associated with anxiety regarding sexual act, and may be due to unconscious fears about vagina and negative cultural conditioning. Men whose early sexual contacts occurred largely with prostitutes who demanded that the sexual act should proceed quickly or whose sexual contacts took place in situations in which
discovery may be embarrassing, might have been conditioned to achieve orgasm rapidly. Lower levels of sexual functioning and satisfaction, and higher levels of personal distress and interpersonal difficulty are reported by men with premature ejaculation and their partners (Rowland, Patrick, Rothman and Gagnon, 2007). Premature ejaculation and sexual desire disorders are the frequent reported problems in young adult males with adverse familial relationship to attachment figures. It is commonly reported among college educated men than men with less education (Sadock and Sadock, 2007). Premature ejaculation is thought to be related to their concern for partner satisfaction.

In sexually normal men, the ejaculatory reflex is, to a considerable extent, under voluntary control. They monitor their sensations during sexual stimulation and are somehow able, perhaps by judicious use of distraction, to forestall the point of ejaculatory inevitability until they decide to “let go” (Kaplan, 1987). Premature ejaculators are for some reason unable to use this technique effectively (Carson, Butcher, Mineka and Hooley, 2007). Physiological factors such as increased penile sensitivity and inflammation of the prostate gland also contribute to premature ejaculation.

**Sexual pain disorders**

In most cases of dyspareunia, dynamic factors are considered causative. Chronic pelvic pain is a common complaint in women with a history of rape or childhood sexual abuse (Sadock and Sadock, 2007; Rellini, Vujanovic and Zvolensky, 2010). Painful coitus can result from tension and anxiety about the sex act that cause women to involuntarily contract their vaginal muscles (Frank, Mistretta and Will, 2008). The pain is real and makes intercourse unpleasant or unbearable. Anticipation of further pain may cause women to avoid coitus altogether (Sadock and Sadock, 2007). If a partner proceeds
with intercourse regardless of a woman's state of readiness, the condition is aggravated. Relationship factors also contribute to dyspareunia. Higher levels of psychological distress, lower levels of marital adjustment, more problems with sexual function and more frequent reports of sexual assault are noticed in women with dyspareunia (Meana, Binik, Khalife and Cohen, 1999). Women with higher frequency of physical complaints in various body areas and insecure attachment style are more susceptible to report pain during intercourse (Granot, Zisman-Ilani, Ram, Goldstick and Yovell, 2010). Davis and Reissing (2007) reported that sexual pain and penetration problems are foremost an interpersonal, intimate experience and partner interaction and adjustment plays major role in the causation of dyspareunia and vaginismus. Dyspareunia can also occur in men, but it is uncommon and is usually associated with an organic condition, such as herpes, prostatitis, or peyronie's disease, which consists of sclerotic plaques on the penis that cause penile curvature (Sadock and Sadock, 2007).

Sexual trauma, such as rape, may cause vaginismus and women with psychosexual conflicts may perceive the penis as a weapon (Sadock and Sadock, 2007). Relationships problems are supposed to be one of the main causes for vaginismus. In a poorly adjusted relationship where women feel emotionally abused by their partners, they may protest in this nonverbal fashion (Sadock and Sadock, 2007). Women with vaginismus may consciously wish to have coitus, but unconsciously wish to keep away a penis from entering their bodies. In some cases, pain or anticipation of pain at the first coital experience causes vaginismus (Sadock and Sadock, 2007). Frank, Mistretta and Will (2008) reported that strict religious upbringing in which sex is associated with sin is frequently noticed among these patients. Stress urinary incontinence is found to negatively influence all aspects of
women’s sexual function (sexual interest, desire, arousal, lubrication, orgasm) and to be significantly correlated with dyspareunia and vaginismus (Lewis, Fugl-Meyer, Bosch, Fugl-Meyer, Laumann, Lizza and Martin-Morales, 2004).

Psychogenic post-ejaculatory pain syndrome (PEPS) is a rare sexual disorder of male dyspareunia and is first described in 1979 as a persistent and recurrent pain in the genital organ during ejaculation or immediately afterward. Ejaculatory pain in the testicular region may result from epididymal congestion after vasectomy or from duct obstruction and/or infection, testicular torsion, mass lesion, or prostatitis. In some cases, specific etiological factors other than psychological stress cannot be identified.

From the above discussion it is clear that multiple etiological factors contribute to various sexual dysfunctions. So a single model approach is insufficient in understanding and in treating different sexual dysfunctions. The various etiological factors of sexual dysfunctions can be summarized into following broad factors.

(1) Physical and physiological factors such as illness, surgery, hormonal problems, irritation from contraceptive materials, and medication.

(2) Early environmental problems, for example, problems in the parents relationship, rape, incest, traumatic experiences with prostitutes, religious orthodoxy and homosexual experiences.

(3) Misinformation and lack of knowledge about sex.

(4) Lack of skilled sexual partner.
Psychological factors such as depressed affect, anxiety, guilt, depression, and fear of losing control.

Relationship problems, including hostility, marital conflicts, lack of communication and lack of attraction towards one’s partner

Cognitive factors such as negative automatic thoughts, incompetence schemas, failure anticipation thoughts, catastrophizing negative consequences, lack of positive thoughts etc.

Other sexual dysfunctions.

**Psychological approaches in the treatment of sexual dysfunction**

The history of sex therapy as a discipline is relatively brief, even though within the last few decades many advances have made in the treatment of sexual dysfunctions. The major approaches in the treatment of sexual dysfunctions include psychodynamic/psychoanalytical, behavioral, cognitive and systemic approaches (Wiederman, 1998). The brief description of the basic assumptions underlying various sex therapy approaches is mentioned below.

**The psychodynamic/ Psychoanalytical approach**

From the start of the twentieth century until the late 1960s, sexual dysfunction is typically treated within a psychoanalytic frame-work (Wiederman, 1998; Comer, 1995). From such a psycho- analytic perspective, sexual problems are viewed as originating from unresolved conflicts dating back to childhood, particularly conflicts over problematic attachments and tension in relation to one’s parents (Patterson and Watkins, 1996). Importantly, the true etiological factors are seen as unconscious (or at least subconscious), and hence associations had to be reconstructed between current problems in sexual functioning and earlier issues (Weinstein and Rosen, 1988). The treatment consisted of long-term, individual
psychotherapy to unmask the underlying (and often unconscious) intrapsychic conflicts that manifested themselves as disruption of "healthy" or "mature" sexual functioning (Carson, Butcher, Mineka and Hooley, 2007; Wiederman, 1998).

**The behavioural approach**

Sex therapy as it is known today was basically founded by Masters and Johnson (1966). In contrast to psychoanalytic approaches, the "new" sex therapy is relatively brief, problem focused, directive and behavioral with regard to technique (Sarason and Sarason, 2005; Wiederman, 1998). Rather than intrapsychic factors, Masters and Johnson (1970) emphasized social and cognitive causes of sexual dysfunction and the majority of sexual difficulties are seen as arising from a sexually restrictive or religiously orthodox upbringing. Masters and Johnson (1970) noted that sexually dysfunctional people has decreased communication with sexual partners, a lack of accurate information about "normal" human sexual functioning, and subsequent anxiety and preoccupation over performance during sexual interactions. Masters and Johnson’s approach is basically a learning model of sexual functioning, and the objectives of treatment consisted of effectively achieving alleviation of performance anxiety and reeducating clients regarding human sexuality. Apart from that, he placed much emphasis to improve the communication between partners. Contrary to psychodynamic approach Masters and Johnson advocated couple model of the treatment. He believed that treatment of couples is essential for sexual problems rather than the person who seems to have the problem; hence, it called as cojoint sex therapy (Sarason and Sarason, 2005).
The Masters and Johnson’s sex therapy included short-term but intensive work with the couple. The therapists conducted their work as a male-female pair of cotherapists; hence, the sex therapy involved four individuals (cotherapists and client couple). Initially the detailed information about relevant human anatomy (structure) and physiology (functioning) is provided to the couples. Then the intervention consisted of direct behavioral exercises, including prescription of non-demand pleasuring, or "sensate focus," wherein the objective is to (re)experience sexual pleasure in the absence of anxiety from perceptions of performance demand or excessive self-monitoring of sexual performance ("spectatoring"). Essentially, clients are aided and encouraged to (re)discover their and their partner's bodies and inherent potential for sexual pleasure. This is accomplished through a series of specific behavioral directives that resulted in pleasurable sensual and sexual experiences in the absence of anxiety.

The PLISSIT model

The American psychologist Jack Annon (1976) developed a simple model illustrating the fact that most people with sexual problems do not need an intensive course of therapy. Though it is developed three decades back, it is being used nowadays very extensively. He used the acronym PLISSIT for the four basic forms of sex therapy; it indicates Permission, Limited Information, Specific Suggestion, and Intensive Therapy. It is developed from the point of view of the different levels of intervention and is ranked in order of increasing intensity.

In the first phase of the treatment the therapist reassures the client/s that their behaviors, thoughts, feelings, fantasies are normal. This is further explained that this is normal as long as the behavior does not negatively impact the other person. Permission-giving includes helping individuals emotionally
process negative sexual experiences in order to facilitate learning from them rather than allowing these experiences to control one’s sexual self-esteem. In the second phase, i.e., limited information, the therapist provides specific information to the client/s regarding their concerns such as sexual response, anxiety, size of one's penis, clitoral response, orgasmic response, effects of medication might have on sexual performance, etc. In the third stage, i.e., specific suggestions, is comprised of homework assignments such as the use of techniques of stop/start techniques, masturbation, or others recommended by the therapist. These are designed for the couple to reach goals such as improved communication, reduce any anxiety, or learn new arousal behaviors. The final phase, intensive therapy, is needed when there are relationship problems which are at the root of the sexual problems. This is the phase required when the first three phases do not resolve the sexual problems. This intensive therapy ranges from psychosexual or insight oriented during which the therapist interprets and reflects to the clients to help them gain awareness of their feelings which may be inhibiting their sexual response.

Cognitive approach
The cognitive approach to sex therapy has its roots to the cognitive therapies of Aron Beck and Albert Ellis. Researchers are paying increasing attention to cognitive underpinning of the sexual behaviour in recent years. Cognitive therapy coupled with behaviour therapy showed satisfying results in the treatment of sexual dysfunctions (LoFrisco, 2011; Bergeron, Morin and Lord, 2010; McCarthy and Thestrup, 2008; McCabe, 2001). It is Barlow (1986) who initially proposed a cognitive model of sexual dysfunctions. Barlow’s cognitive-affective model postulated that the interaction between autonomic arousal (sympathetic activation) and cognitive interference plays
a central role in determining sexually functional and dysfunctional responses. Sbrocco and Barlow (1996) and Wiegel, Scepkowski and Barlow (2007) further developed the original model, indicating that schematic vulnerability is one of the main components implicated in sexual dysfunction. They postulated that the schema concept consists of ideas people have about sexuality and themselves as sexual beings and include a set of standards and expectations regarding sexual issues. Sbrocco and Barlow (1996) suggested that individuals with sexual dysfunction have a set of sexual beliefs that are usually unrealistic and inaccurate, and assume a rigid and inflexible character. Whenever these demanding and unrealistic referential standards are not met, catastrophic personal implications may arise, facilitating the development of negative self-views (negative self-schemas) and predisposing individuals to develop sexual difficulties.

Therefore the cognitive approach indicates that men and women with sexual dysfunction activate significantly more incompetent self-schemas (e.g., “I’m incompetent,” “I’m a failure”) whenever they experience an unsuccessful sexual situation. These self-critical schemas, once activated, elicit negative automatic thoughts (failure anticipation thoughts and erection concern thoughts in men, and disengagement thoughts and sexual abuse thoughts in women) that prevent them from focusing on erotic stimuli (lack of erotic thoughts) and promote lack of positive emotions (sadness, disillusion, guilt, and lack of pleasure and satisfaction). Recent research in cognitive basis of sexual dysfunction suggests a cognitive-emotional interference similar to the one observed in depression (Carvalho and Nobre, 2011; Nobre, 2009; Nobre and Pinto-Gouveia, 2009).

The goal of cognitive work in sex therapy is to modify patient’s problematic cognitions regarding sexual functioning (Gomes and Nobre, 2011; Carvalho
and Nobre, 2011; Nobre and Pinto-Gouveia, 2009; Wiegel, Scepkowski and Barlow, 2007; Wiederman, 1998). Often this work includes dispelling myths about male and female sexuality, changing the schemas and negative automatic thoughts and helping the client to focus his or her attention on sexual sensations and pleasure rather than on performance. So the therapeutic process comprised of actively challenging and modifying the troublesome beliefs, attitudes and expectations underlying the dysfunction in sexual behavior.

**Systemic approach**

From systems perspective, sexuality entails interpersonal intimacy and interaction with a partner. The belief is that one needs to appreciate the dynamic interplay between the two individuals involved in a sexual relationship (Talmadge and Talmadge, 1986). Systemic approach proposes that each partner brings to the general relationship a set of developmental experiences embedded in their family of origin as well as the larger social system, and these experiences within other systems have an impact on the meanings each individual ascribes to the behaviors of the other partner (Hof and Berman, 1986). It also emphasizes that, for any couple, the sexual interaction does not occur in a vacuum but rather within the larger context of their ongoing relationship. Hence, relationship conflicts in nonsexual domains (e.g., a relative imbalance of power in the relationship) are believed significantly to affect sexual functioning of one or both partners (Bogarozzi, 1987).

In systems approach, the sexual problem is seen as an indicative of problems elsewhere in the relationship, or the sexual problem is believed to serve some larger function within the relationship. The goal of sex therapy in systems approach is to address the underlying relationship dynamic that happens to
be manifesting itself as the apparent sexual problem. Theorists from this perspective seem to believe that improvement of sexual functioning in the absence of changing problematic relationship dynamics may result in the creation of other psychological symptoms.

**Psychological management of sexual dysfunction**

**Sensate focus**

Sensate focus is probably the best known of Masters and Johnson’s sexual retraining techniques. Sensate focus plays an important role in the treatment of sexual dysfunctions. It is being used for almost all sexual problems such as, fear of pain, fear of failure, lack of sexual desire, inability to get erection, ejaculatory problems, orgasmic difficulty, and so forth. Sensate focus also acts as a good diagnostic tool; it reveals many of the underlying problems between couples while they do their homework assignments and can be analyzed in therapy (Masters and Johnson, 1970).

The rationale behind sensate focus is that sexually dysfunctional couples have lost the ability to think and feel in a sensual way because of various stresses and pressures they associate with intercourse (Masters and Johnson, 1970). Therefore, they are to be reacquainted with the pleasures of tactile contact. The model has three stages: (i) non-genital focus (ii) genital sensate focus and (iii) vaginal containment. These stages can vary in duration depending on the quality of the relationship and the commitment of both parties. The first stage of the model provides couples an opportunity for tactile intimacy without the need to achieve sexual goals. They are required to focus only on sensations experienced through body massage and caress, and are forbidden to touch the genital or breast areas. This allows them both relaxation and discovery. When it is appropriate they move to the next stage which incorporates the sexual areas but not for sexual stimulation and so
towards sexual stimulation before moving to the third stage, which is vaginal containment. The sensate focus engages the couple in the change process, whereas it provides the clinician with a continuous assessment method to identify anxieties, inhibitions, and psychosexual skill deficits.

**The squeeze procedure**
The Squeeze Procedure is another technique developed by Masters and Johnson (1970) and is proved to be very effective in the treatment of premature ejaculation. In this technique, when man is about to ejaculate, the women is instructed to squeeze her partner’s penis for about three to four seconds. Rather strong pressure is applied under and behind the glans around the coronal ridge. This squeeze technique is said to immediately eliminate the urge to ejaculate, and it may also cause the male to lose 10% to 30% of his erection. The wife waits fifteen to thirty seconds, and then repeats the procedure. After practicing for a few days, the couple repeats the procedure with intravaginal containment of the penis, but no thrusting, to produce stimulation. The next steps are intravaginal containment with slow movement, and then fast movement, using the squeeze as before.

**The pause procedure or Stop-start technique**
Pause procedure is developed by James Semans in 1956. This is also proved to be effective in the treatment of premature ejaculation. Basically, the problem of premature ejaculation is the male’s low threshold for amount of stimulation required to elicit the ejaculation response. In semans technique, the penis is stimulated until ejaculation is imminent. At this point stimulation is stopped. The male pauses and also signals his partner to stop, until the sensation of high arousal subsides, and then begins stimulation of the penis again. This procedure is repeated over and over again. The number of pauses required to sustain stimulation and delay ejaculation rapidly decreases over
successive occasions with this procedure, and the male soon gains the capacity for penile stimulation of great duration without any pauses at all.

**The dilatation therapy**

A graduated series of dilators is used to enable woman to learn to tolerate vaginal intromission (LoPiccolo and Lobitz, 1972; Wiederman, 1998). The dilation program is carried out by the patient’s husband and/or patient herself at home. Dilators and husband’s or patient’s fingers are used for this program. One might commence with the tip of a cotton bud, or the tip of patient’s little finger, followed by gradual insertion of two or more fingers, various lubricated cylinders, and eventually by the gradual introduction of the penis, culminating with vigorous coital movement. It was initially presented by Rachman in 1959; later Masters and Johnson (1970) developed it as a treatment for vaginismus. Dilators are used for the treatment of vaginismus, dyspareunia, female orgasmic disorder etc. (Sadock and Sadock, 2007).

**Masturbation therapy**

Masturbation is included in a number of treatment packages using structured sexual experiences. It is useful for a number of reasons: (1) it is not as anxiety provoking as heterosexual behaviour for some clients, so it is useful as an initial step in the hierarchy of activities or treatment program (Kaplan, 1974); (2) it enables the client to find out what types of stimulation are most arousing for him or her, so that he or she can then teach his or her partner these methods of stimulation (Annon, 1974; LoPiccolo and Lobitz, 1972); (3) Kinsey, Pomeroy, Martin and Gebhard (1953) found that women are more likely to reach orgasm through masturbation than through any other technique; (4) Masters and Johnson (1966) found that masturbation leads to more intense orgasm than intercourse or manual stimulation by the partner; (5) it is useful for clients who do not have partners (Annon, 1974); (6) it is a
good way for a male to practice the squeeze or pause technique for premature ejaculation without any performance demands from his partner (Masters and Johnson, 1970); and (7) it can be used to increase the frequency of orgasm, leading to a longer ejaculation latency in men suffering from premature ejaculation (Annon, 1974). Masturbation is commonly used in the treatment of male sexual desire disorders, male erectile disorder, male orgasmic disorder, premature ejaculation, female sexual desire disorders, female arousal disorders, female orgasmic disorders, vaginismus and in dyspareunia (Sadock and Sadock, 2007).

**Kegel exercises**
Kegel exercises are developed by Kegel in 1948. Kegel exercises are utilized to enhance person’s orgasmic potential through increasing strength and vascularity of the pelvic musculature. It is a means of enabling the woman to attain voluntary control of these muscles. The person volitionally and repeatedly tightens the muscles of the perineum for 3 to 4 minutes; by doing these exercises a few times a day helps to keep the muscle tone of the perineum taut and more satisfactory for both partners during sex. This exercise is valuable for both men and women. It is being widely used in the treatment of various sexual dysfunctions.

**Systematic desensitization**
The systematic desensitization is been used successfully in the treatment of sexual dysfunctions. It is being used mainly to reduce anxiety and fear associated with sexual functioning (Sadock and Sadock, 2007). It is being used in the treatment of erectile dysfunction, premature ejaculation, vaginismus, anorgasmia, dyspareunia etc. From behavioural perspective, Masters and Johnson’s technique of sensate focus is reminiscent of
systematic desensitization, as it leads to the substitution of a pleasurable response for anxiety (Sarason and Sarason, 2005).

In systematic desensitization a behaviour that is incompatible with being anxious is taken and repeatedly pairs it with the stimulus that provokes anxiety in the patient. Because it is difficult, if not impossible to feel both pleasant and anxious at the same time, systematic desensitization is aimed at teaching a person, while in the presence of the anxiety producing stimulus, to relax or behave in some other way that is inconsistent with anxiety (Carson, Butcher, Mineka and Hooley, 2007). The therapy procedure comprised of teaching the client to enter a state of relaxation, typically by progressive concentration on relaxing various muscle groups. Meanwhile, patient and therapist collaborate in constructing an anxiety hierarchy that consists of imagined scenes graded as to their capacity to elicit anxiety. In the therapy sessions, after making the patient in a relaxed state, presentation of this lowest anxiety evoking item to the highest anxiety evoking items is carried out. In the meantime the client is encouraged to concentrate on the relaxed state while imaging those situations. Once the client is able to remain relaxed, progressively more upsetting scenes are presented.

**Relaxation therapy**

Relaxation therapy is employed in persons with sexual dysfunctions in order to alleviate anxiety and to achieve deep muscle relaxation. Relaxation produces physiological and psychological effects opposite to those of anxiety such as, decrease in muscle tension, respiration rate, heart rate, skin conductance, and increase in peripheral blood flow, neuromuscular stability, and psychological state of well being (Sadock and Sadock, 2007). The deep relaxation reduces the autonomic arousal level. In anxiety state the sympathetic nervous system of the autonomic nerve system is dominant,
whereas, in the relaxation state the parasympathetic nervous system of the autonomic nerve system is dominant. As erection is a function of parasympathetic nerve system relaxation therapy can be helpful in the treatment of various sexual dysfunctions, such as arousal disorders, orgasmic disorders and pain disorders.

One of the most used relaxation method is progressive muscular relaxation developed by Edmund Jacobson (1938). In this method patients are asked to take comfortable position on the bed and are given instructions to alternately tense and relax various muscle groups in a fixed order, starting from hands and proceeds through arms, face, neck, shoulders, back, chest, stomach, breathing, hips, legs and to feet while concentrating on the feelings of tension and relaxation.

**Sex education**

Sex education is considered as an essential component of management strategy (Hatzichristou, Rosen, Broderick, Clayton, Cuzin, Derogatis, Litwin, Meuleman, O’Leary, Quirk, Sadovsky and Seftel, 2004). Masters and Johnson (1970) believed that imparting proper information on sexuality can remove many of the underlying myths and misconceptions about sexuality. The presentation of this basic information often has important therapeutic benefits in itself. Sex education procedure comprised of the basic information about sexuality, the anatomy and physiology of sex, the sexual response cycle etc.

**Analytically oriented sex therapy**

One of the effective treatment modalities is the use of sex therapy integrated with psychodynamic and psychoanalytically oriented psychotherapy. The sex therapy is conducted over a longer period than usual, which allows learning
or relearning of sexual satisfaction under the realities of patient’s day-to-day life. The material and dynamics that emerge in patients in analytically oriented sex therapy are the same as those in psychoanalytic therapy, such as dreams, fear of punishment, aggressive feelings, difficulty to trust partner, fear of intimacy, oedipal feelings, and fear of genital mutilation. The combined approach of analytically oriented sex therapy is used by sex therapist who carefully judges the optimal timing of sex therapy and the ability of patients to tolerate the directive approach that focuses on their sexual difficulties.

**Cognitive therapy**
Cognitive therapy involves identifying maladaptive thoughts and underlying dysfunctional assumptions and beliefs, and modifying them with more adaptive thoughts. Cognitive therapy is used in the treatment of sexual dysfunction to challenge and deal with maladaptive thoughts commonly encountered in patients with sexual dysfunction, such as, “My partner will leave me if I continue to lose my erections”; “I cannot get erections any more”; “I cannot satisfy my husband/wife”; “I am no longer exciting to him”; “He is just not trying”; “she must be having an affair with someone”…etc. The basis for these thoughts is then examined and altered using socratic dialogue and reattribution techniques. Partners are taught to identify their existing negative thoughts and encouraged to replace them with more adaptive and healthy thoughts.

**Relationship therapy/Marital therapy**
Relationship therapy is used in the treatment of sexual dysfunctions to improve the relationship between the partners. It is directed toward helping couples to overcome their difficulties and discuss differences between them without having emotional explosions. The objective of the
relationship/marital therapy in the treatment of sexual dysfunctions is the establishment of emotionally secure relationship that allows normal sexual response to occur and to be enjoyed (McCarthy and Thesstrup, 2008). It is employed to focus on the basic elements of the relationship, on the assumption that unless the relationship works well with good communication and both partners feeling secure, it will be difficult to alter the specific sexual problem (Sadock and Sadock, 2007). The new mantra in sex therapy is focus on establishing a mutually acceptable level of intimacy, integrating non-demand pleasuring, adding erotic scenarios and techniques, and establishing positive, realistic sexual expectations (McCarthy and Thesstrup, 2008).

**Sex knowledge**

Adequate knowledge about sex is an important factor for healthy sexual functioning, whereas poor knowledge about sex is often associated with sexual dysfunction (Sidi, Midin, Wan-Puteh and Abdullah, 2008; Kendurkar, Kaur, Agarwal, Singh and Agarwal, 2008). Poor sex knowledge is considered as an important causative variable for sexual dysfunction in many studies (Masters and Johnson, 1970; Kaplan, 1974; LoPiccolo, 1994; McKelvey, Webb, Baldassar, Robinson and Riley 2002; Westwood and Mullan, 2007; Trimble, 2009). Poor sex knowledge is present in many persons irrespective of their profession and education. Hinchliff and Gott (2011) reported that even family physicians lacks proper knowledge about sexuality and various treatment options for sexual dysfunction. Due to the outdated knowledge, lack of time and lack of training, family practitioners avoids to discuss sexually related matters with their patients. Gott, Galena, Hinchliff and Elford (2004) also pointed out that GPs and practicing nurses do not address sexual health issues proactively with patients. Westwood and Mullan (2007) noted that teachers who are expected to impart sex education
do not have sufficient knowledge to provide young people with adequate sexual health education and as a result, in many cases they prefer not to teach these programs. Their study revealed that persons who are supposed to teach and treat the sexual problems are not quipped to do so.

Sex knowledge can be defined as ‘the general and specific information, acquaintance, and cognition about sex, especially human sex relationships and behaviour without any implication of evaluation of such relationship and behaviour’ (Avasthi, Varma, Nehra and Das, 1992). The attitude towards sex is referred to ‘one’s position, posture, gesture towards sexual relationship and behaviour. It includes beliefs (knowledge), liking-disliking (affect) and action tendencies (behavior)’ (Avasthi, Varma, Nehra and Das, 1992). Thus, human sexual behaviour is said to be a complex interplay of distinctive as well as learned phenomena and modulated by psychosocial factors. Mathew and Joseph (2009) pointed out that sex knowledge is an important component for the healthy sexual functioning of an individual and inadequate sex knowledge paves way for myths, misconceptions, dysfunctional beliefs and ignorance.

Masters and Johnson (1966) reported that ‘it is ignorance more than anything else that causes sexual dysfunction’. Kaplan (1974) pointed out that couple with sexual problems typically practice insensitive, incompetent and ineffective sexual techniques. The majority of clients presenting with sexual dysfunctions are ignorant about many aspects of sex, have certain misconceptions about sexual functioning, and / or are deficient in techniques of sexual stimulation (Avasthi, Sharan and Nehra, 2003; Sadock and Sadock, 2007). Ignorance regarding sexual intercourse and sex organs e.g.; faulty positions, faulty movements, and length and size of the sex organs, account for a large number of sexual problems, which in turn, disturbs marital
relationships (Mathew and Joseph, 2009). The ignorance or misinformation regarding sex may derive from a lack of anatomical knowledge about normal sexual physiology or be related directly to cultural myths or taboos (Sarason and Sarason, 2005; Mathew and Joseph, 2009). Myths, misinformation, unrealistic expectations, communication failures and destructive behavior patterns are common in persons with sexual problems (Masters, Johnson and Kolodny, 1985; Sadock and Sadock, 2007).

Sexual ignorance or more commonly misconceptions coupled with attitudinal problems play a significant role in the causation as well as perpetuation of the disorder (Kolodny and Masters, 1970; Beutler, Thornby, Karacan and Walker, 1980). Nobre and Pinto-Gouveia (2006a) pointed out that misconceptions and dysfunctional sexual beliefs as vulnerability factors to sexual dysfunction. They found that both dysfunctional men and women endorsed more sexual dysfunctional beliefs than functional. The misconceptions and dysfunctional belief such as, ‘loss of semen means loss of vitality’, ‘one drop of semen equals to 40 drops of blood’, ‘the size of a man’s penis is directly related to his virility and to the pleasure he can give a women during intercourse’, ‘I can not satisfy my partner’, ‘women who are not physically attractive cannot be sexually satisfied’, ‘after menopause women loose their sexual desire’, ‘as women age, the pleasure they get from sex decreases’, ‘a real man has sexual intercourse very often’ and ‘the quality of the erection is what most satisfies women’ etc are common in sexually dysfunctional people (Nobre and Pinto-Gouveia, 2006a).

Masters and Johnson (1970) reported that everyone mentally constructs for himself, from early childhood onward through adolescence and youth, a value system with regard to sexual activity. Sex can be thought of as beautiful or dirty, redeeming or sinful, pleasurable or painful, permissible in
one situation but not in another. This value system affects, positively or negatively, an individual’s natural physical capacity to function sexually (Masters and Johnson, 1976). The recent research in the cognitive aspects of sexual dysfunction agrees with Masters and Johnson’s findings. Sbrocco and Barlow (1996) and Wiegel, Scepkowski and Barlow (2007) reported that the ideas people develop about sexuality and about themselves as sexual beings is significant in their sexual functioning. Sbrocco and Barlow (1996) suggested that individuals with sexual dysfunction have a set of sexual beliefs that are usually unrealistic and inaccurate, and assume a rigid and inflexible character. Whenever these demanding and unrealistic referential standards are not met, catastrophic personal implications may arise, facilitating the development of negative self-views (negative self-schemas) and predisposing individuals to develop sexual difficulties. Sometimes the natural sexual drive is enough to overcome native sexual attitudes, in other instances it is not. Masters and Johnson (1976) found that it is especially important for the dysfunctional couples to understand the effects of their negative attitudes towards sex on their ability to function normally. They pointed out that understanding these negative attitudes will enable them to neutralize its harmful effects.

Double standard in sex is commonly noticed in a society where lots of myths and misconceptions prevail among its people (Lyons, Giordano, Manning and Longmore, 2011; Mathew and Joseph, 2009). The idea of sexual double standard emphasizes that men have more sexual freedom, whereas women are subject to social sanctions for the same behaviors (Lyons, Giordano, Manning and Longmore, 2011). This double standard in sex offers a set of permissive attitudes for men another set of restrictive ones for women (Masters and Johnson 1970). Khan, Hudson-Rodd, Saggers, Bhuiyan,
Bhuiya, Karim and Rauyajin (2008) pointed out that men without adequate knowledge of human sexuality deem ‘sex’ as another agency of power, dominance and governance. Sexual performance with a large-sized penis is symbolized as masculine power to control women. Narrowly focused penetrative male sexuality is relied on performance, which destroys the quality of sexual life and equality in relationships. Male superiority and power over women are proclaimed as ‘normal’ and ‘natural’ in such societies. Men’s authoritative relations with women affects sexual acts, where ‘real’ men need to be sexually ‘potent’ to demonstrate ‘sexual power’ through sustained penile erections, penetration and prolonged sexual intercourse. This double standard has created a male domination in sex and subsequently has led a submissive role for women in sex. This has prevented many women from allowing themselves to enjoy their sexual feelings. Mathew and Joseph (2009) reported this submissive role of Indian women and pointed out that many of Indian women still lives in sexual denial. At the same time, this cultural concept that male partner must accept full responsibility for establishing successful coital connection is placed upon every man a psychological burden for coital process and is released every women from any suggestion of similar responsibility for its success (Masters and Johnson, 1970).

There is also a relation between sex knowledge and religiosity. McKelvey, Webb, Baldassar, Robinson and Riley (2002) noted that those who attend more in religious activities express more negative attitude in sex. Masters and Johnson (1970) reported that the single most common factor in the backgrounds of sexually dysfunctional people is rigid adherence to religious restrictions. In some extreme religious families sex is regarded as degrading if not sinful, and the sexual intercourse is tolerated for the purpose of
procreation only (Belliveau and Richter, 1970). The religious prohibitions cause extreme stress when a man or woman first tries having intercourse. The destructiveness of denial and repression backed by religious sanctions never let these people to have sex in an uninhibited way (Masters and Johnson, 1976). Shirpak, Ardebili, Mohammad, Maticka-Tyndale, Chinichian, Ramenzankhani and Fotouhi (2007) reported that imparting sex education is highly difficult or an impossible task in extremely religious societies and societies that follow strict rules and laws.

Societal and parental negative attitudes toward sexual expression, past traumatic experiences etc. can also make a person sexually dysfunctional (Lo Piccolo and Stock, 1986). More recently, Kendurkar, Kaur, Agarwal, Singh and Agarwal (2008) pointed out that culturally held beliefs have strong influence on sexual activity of an individual. Early sexual prohibitions, restrictions and faulty learning have strong influence on their sexual functioning in their marital life. This influence is more troublesome for young and unmarried persons who are not changed over the period. In some primitive societies older members of the group instruct younger members in sexual techniques before marriage. But in our society, though we recognize that sexual behaviour is an important aspect of marriage, learning of sexual technique is often left to chance (Mahajan and Sharma, 2005). As a result many young people start off with faulty expectations. Consequently young boys and girls reaching puberty go through enormous stress and guilt feelings. Some carry this guilt into marriage, creating anxiety and thus inhibiting normal sexual response.

Mahajan and Sharma (2005) reported that, in India mothers are reluctant to talk about the basic information regarding sex to their daughter as they found it embarrassing to discuss these issues. They avoid any mention of sex in
their day-to-day relationships with their children. This may be because, sex is being considered as a taboo subject in Indian society and parents themselves lack scientific knowledge about it. The lack of information or misinformation regarding reproduction and sexuality contribute to the high rate of abortion amongst adolescents in India (Bhan, Mahajan and Sondhi, 2004). Verma, Khaitan and Singh (1998) attributed higher frequency of the sexual problems in Indian population to the lack of proper sex knowledge. Bhan, Mahajan and Sondhi (2004) reported of poor level of sex knowledge in the Indian youth, especially in young girls. A matter of serious concern is the fact that Indian students have no reliable means of obtaining correct information (Bhan, Mahajan and Sondhi, 2004). Sex education is not included in the curriculum of Indian schools till now. It is very sad to note that, even though it is the most literate state in India, kerala does not impart sex education either in schools or in colleges. As a result, sex remains as the most tabooed, under-researched and mal-practiced condition in India. In Indian culture, people are even hesitant to talk about sex topics, because, it considered as sinful, secret and stigmatizing issue. This throws light into the fact that people should be taught about sex in their early ages in order to stay away from myths, misconceptions, faulty expectations and high risk sexual behaviours.

Imparting sex education early in life is the solution to many problems. Education aimed at increasing sex knowledge and modifying negative attitudes towards sex may enhance individuals’ sexual functioning (McKelvey, Webb, Baldassar, Robinson and Riley, 2002). Singh, Bankole and Woog (2005) pointed out that people should be provided with sex education in their young ages, so that they can solve many of the problems in their later life. In our modernized society people should be taught about sex in their young ages, because of their early initiation of sexual activity, high-
risk sexual behaviours they are engaging in and involuntary context within which they have sexual intercourse. Adequate level of sex knowledge will enable them to protect their sexual health. Mturi and Hennink (2005) pointed out that introducing sex education in the national school curriculum can help young people, parents as well as the teachers. This will help them to acquire adequate knowledge about sex and sexual functioning, to develop sexual skills and enable them to withstand the sexual pressures. In conclusion, adequate sex knowledge is an essential factor for healthy sexual functioning and should be taught in the young age itself. This will enable them to lead satisfactory marital and sexual life.

**Marital adjustment**

Marriage is a commitment with love and responsibility for peace, happiness and development of a strong family relationship. Marriage provides a person an opportunity for his needs for companionship, affection and sexual expression. Marriage is the most intimate type of emotional relationship between two individuals. Marital relationship is conceptualized as the interaction of two persons (Sarason and Sarason, 2005). The success in marriage is said to depend partly on finding the right person and partly on being the right person. But the mere fact that two persons are suited to each other does not guarantee that they will make a successful marital relationship, rather their level of adjustment decides the success of their marital and sexual relationship (Cohen, Geron and Farchi, 2009). It implies that partner’s ability to share, accommodate, accept, compromise, and plan together determines the success in the relationship. It is noticed that the phenomenon of marital adjustment is given a priority in all cultures, as marriage is one of the most important commitment an individual makes in
his or her life. It is revealed that good marriage not only produces a satisfied life but it also generates a sense of well-being.

Marital adjustment is characterized by mutual acceptance, trust, care, concern, love, admiration and sharing of role responsibilities (Kumar and Rohatgi, 1976). This implies considerable change in their personalities they bring with them at the time of marriage. In short a good marriage does not simply happen rather it is to be worked out. Marital adjustment calls for maturity that accepts and understands growth and development in the spouse. If this growth is not experienced and realized fully, problems in marital relationship is inevitable. A relationship between couples is not instantaneous rather a slow progress. Marital adjustment is the state in which there is an overall feeling in husband and wife of happiness and satisfaction with their marriage and with each other. Marital adjustment is defined in ten areas, i.e. values, couple growth, communication, conflict resolution, affection, roles, cooperation, sex, money and parenthood (Hashmi, Khurshid and Hassan, 2007). A study on marriage and marital adjustment in USA presents social activities and recreation, training and disciplining of children, religion, in-law relationship, financial matters, sexual relationship, communication, mutual trust and companionship as the areas of marital adjustment (Hashmi, Khurshid and Hassan, 2007).

Marital problems arise when the two partners fails in their relationship. Object relations theorists propose that each spouse’s striving for individuation and separation, and for attachment and commitment are ongoing sources of conflict in marriage (Finkelstein, 1987; Insraelstam, 1989; Carson, Butcher, Mineka and Hooley, 2007). Role theory perspective suggested that discrepancies between role expectation and role performance give rise to marital problems (Tharp, 1963). Marital dysfunction is viewed as
a disorder originating primarily within the interaction of the relationship. Marital conflict occurs when one partner’s desire to change the behaviour of the other in the face of noncompliance. It is characterized by the exchange of relatively low rates or quality of pleasing behaviour, or relatively high rates or an intense quality of displeasing behaviour, or a combination of both (Anderson, Anderson, Palmer, Mutchler and Baker, 2010). Marital conflict becomes dysfunctional when it causes psychological/physical injury, decreased interpersonal trust, and fails to generate change in subsequent marital interactions (Feldman, 1982; Friedman, 2004).

Some of the areas with which conflicts often surrounded are the division of house-hold labor, financial matters, child rearing, working hours, sexual issues, leisure activities, communication issues and extra marital affairs (Kluwer, Heesink and Vliert, 1996; Henry and Miller, 2004). The changes that take place in the family life cycle, demands increased level of adjustment from couples, if not it can lead to marital conflicts. Length of marriage, parenthood, presence of children, retirement of the partner, menopause etc. are some of the events that making a difference to the satisfaction of couples at different stages of family life cycle. It depends upon couple’s ability to adjust with these changes and day to day hassles of life make their relationship satisfactory. In healthy marriages, supportive conciliatory and trusting behaviour helps to settle conflicts.

Satisfaction in marital and sexual relationship is the most basic ingredient of marital adjustment. The maintenance and endurance of a quality marital relationship is in part a function of couple’s abilities to accomplish certain relationship goals, such as communicating and problem solving, obtaining and keeping a job, maintaining a home, raising children, handling finances, and maintaining a satisfying sex life. Some couples naturally acquire these
skills before or within the relationship, but some are not. Conflict resolution style of couples is an important factor that determining marital satisfaction (Schneewind and Gerhard, 2002). The ability of couples to solve problems that occurs in day to day life determines happiness and duration of marriage (Kurdek, 1995; Friedman, 2004); whereas hostile and distancing behaviors among couples are associated with marital distress (Roberts, 2000).

Communication skills of couples are related to their marital and sexual satisfaction (Burleson and Denton, 1997). Poor communication between couples is lead to marital distress and sometimes it is seen as the sign of marital conflict (Klinetob and Smith, 1996). Masters and Johnson (1970) advocated that communication problems are commonly seen in sexually dysfunctional couples. They reported that such couples usually are reluctant to talk or express their sexual interests or needs. Miller, Caughlin and Huston (2003) found that expressiveness promotes satisfaction by leading spouses to engage in affectionate behavior and by leading them to idealize their partner. Sacco and Phares (2001) pointed out that people are more maritally satisfied when their partners viewed them positively and less satisfied when their partners viewed them negatively. It indicates the importance better communication skills and intimacy in marital relationship. Hinchliff and Gott (2004) reported that sex and intimacy are the important factors for marital satisfaction throughout the lifespan, including old age. More recently, McCarthy and Thestrup (2008) also reported similar findings that emotional intimacy serves as the foundation for healthy relationship and sexuality. Basson (2006) reported that it is the marriage that provides the best framework for sexual relationship and sexuality is a positive and integral component of couple relationship.
Problems in marital relationship affects couple’s sexual functioning (Balon, 2010; Sadock and Sadock, 2007; Carson, Butcher, Mineka and Hooley, 2007). Marital problems play an important role in the causation of sexual dysfunctions (Carson, Butcher, Mineka and Hooley, 2007). Traeen (2010) reported that abundance of sexual problems is present in the clinical samples of marital disharmony. There is always been a considerable overlap in the symptomatology between clients presenting with marital problems and patients presenting with sexual dysfunctions. There is also a complex interaction and interdependence between marital and sexual complaints (McCabe and Goldhammer, 2012).

In a marital relationship one individual may find his or her sexual partner physically or psychologically repulsive, or may have hostile and antagonistic feelings as a result of prior misunderstandings, quarrels and conflicts. Often a one-sided interpersonal relationship - in which one partner does most of the giving and the other most of the receiving – can lead to feeling of insecurity and resentment and can result in impairment in sexual performance (Freidman, 2004). Lack of emotional closeness towards partner often leads to poor sexual functioning. It can also result from intercourse with a partner who does not care for his or her sexual needs. When the partner is rough, unduly hasty and concerned only with his/her own gratification it can create problems in sexual life. In other instances, the individual may be hostile toward and not want to please his or her sexual partner. This seems to occur rather frequently in unhappy and failing marital relationships, in which chances of communication have largely broken down and sex is performed as a sort of habit or duty or simply to gratify one’s own sexual needs.
Dennerstein, Hayes, Sand and Lehert (2009) reported that couples with inadequate partner interaction have reduced level of sexual interest. In their study higher sexual interest is significantly associated with comparatively positive partner interaction scores. The study concluded that women suffering from characteristics of hypoactive sexual desire disorder have more negative patterns of partner interactions. Sadock and Sadock (2007) expressed that lack or loss of sexual desire is a sign of deteriorating relationship or an expression of hostility towards the partner. Issues of inhibited sexual desire and discrepancies in sexual desire are the most common sexual problems among marital dysfunctional couples (Basson, 2006). The difficulties between partners such as inability to trust, feelings of inadequacy or a sense of being undesirable as a partner, difficulties to communicate ones needs or anger in a direct and constructive way are implied in the erectile dysfunction (Sadock and Sadock, 2007). Theorgasmic disorder frequently reflects interpersonal difficulties. The maleorgasmic disorder is supposed to be man’s way of coping with real or fantasized changes in a relationship, such as plans for pregnancy about which the man is ambivalent, loss of sexual attraction to the partner, or demands by the partner for greater commitment as expressed by sexual performance (Sadock and Sadock, 2007). In some men, inability to ejaculate is indicated as unexpressed hostility towards woman. Premature ejaculation is found to be exacerbated with stressful marital relationship (Sadock and Sadock, 2007). The relationship problems also noted in sexual pain disorders and the pain is usually aggravated by relationship conflicts; it is also seen as a protest towards partner in a nonverbal fashion (Carson, Butcher, Mineka and Hooley, 2007). So the new mantra in sex therapy is establishing a mutually acceptable level of intimacy, integrating non-demand pleasuring, adding
erotic scenarios and techniques, and establishing positive and realistic sexual expectations (McCarthy and Thstrup, 2008).

From the above findings we can conclude that relationship problems can affect the sexual functioning of couples. Sex can be seen as the result of better interpersonal skills among couples. Better interpersonal skills result in better marital adjustment and better marital adjustment result in enhanced sexual functioning. Therefore, the key to have satisfactory sex among couples is to maintain their relationship efficiently. In other words, success in marriage depends on ones’ ability to have adequate interpersonal and intrapersonal skills. A better interpersonal and intrapersonal skill means better emotional intelligence. A person with adequate emotional intelligence can lead a happy marital and sexual life.

**Emotional intelligence**

Emotional intelligence of a person is reported to play a vital role in his relational and sexual functioning. The marital and sexual satisfaction of an individual is depended on his ability to understand, perceive, use and manage his and of his partners’ emotions effectively. It is now obvious that emotional competencies or emotional intelligence of a person determine his success in life. Goleman (1998) reported that emotional competencies or emotional skills matters more than academic intelligence in shaping ones’ personal destiny. And how proficient a person is at these skills is crucial in understanding why one person thrives in life while another, of equal intellect fails. People who are emotionally adept – who know and manage their own feelings well, and who read and deal effectively with other people’s feelings – are at an advantage in any domain of life, whether in intimate and sexual relationships or picking up the unspoken rules that govern success in
organizational politics. People with well-developed emotional skills are also more likely to be content and effective in their lives, leading a happy marital, as well as social life. People who can not marshal some control over their emotional life fight inner battles that sabotage their ability for focused work and clear thought (Mayer and Salovey, 1997).

Emotion is referred to a feeling and its distinctive thoughts, psychological and biological states, and range of propensities to act (Goleman, 1995). The very root of the word emotion is ‘motere’, the latin verb “to move”, plus the prefix “e-” to connote “move away”, suggesting that a tendency to act is implicit in every emotion (Goleman, 1995). All emotions are, in essence, impulses to act, the instant plans for handling life that evolution has instilled in us. Every strong emotion has at its root an impulse to action; managing those impulses is basic to emotional intelligence (Goleman, 1995). The concept of emotional intelligence (EI) can be attributed to a comprehensive package of individual skills and dispositions, usually referred to as soft skills or interpersonal and intrapersonal skills, which make up the competency profile of a person. Goleman (1998) defined emotional intelligence as “the capacity for recognizing our own feelings and those of others, for motivating ourselves, and for managing emotions well in ourselves and in our relationships”. Mayer and Salovey (1997) defined emotional intelligence as “the ability to perceive emotions, to access and generate emotions so as to assist thought, to understand emotions and emotional knowledge, and to reflectively regulate emotions so as to promote emotional and intellectual growth”. Bar-On (1997) stated that “emotional intelligence reflects one’s ability to deal with daily environment challenges and helps to predict one’s success in life, including professional and personal pursuits”. The two major dimensions of emotional intelligence are interpersonal and intrapersonal intelligence, which is similar to
Gardner’s Personal intelligence (Gardner, 1983). The interpersonal intelligence is defined as “the capacities to discern and respond appropriately to the moods, temperaments, motivations and desires of other people”. The intrapersonal intelligence, the key to self-knowledge, is defined as “access to one’s own feelings and the ability to discriminate among them and draw upon them to guide behaviour” (Gardner, 1983).

Mayer and Salovey (1997) pointed out that emotional intelligence includes four types of abilities, such as,

1. Perceiving emotions — the ability to detect and decipher emotions in faces, pictures, voices, and cultural artifacts— including the ability to identify one’s own emotions. Perceiving emotions represents a basic aspect of emotional intelligence, as it makes all other processing of emotional information possible.

2. Using emotions — the ability to harness emotions to facilitate various cognitive activities, such as thinking and problem solving. The emotionally intelligent person can capitalize fully upon his or her changing moods in order to best fit the task at hand.

3. Understanding emotions — the ability to comprehend emotion language and to appreciate complicated relationships among emotions. For example, understanding emotions encompasses the ability to be sensitive to slight variations between emotions, and the ability to recognize and describe how emotions evolve over time.

4. Managing emotions — the ability to regulate emotions in both ourselves and in others. Therefore, the emotionally intelligent person can harness emotions, even negative ones, and manage them to achieve intended goals.
Daniel Goleman's (1998) model of emotional intelligence consisted of four main constructs, such as,

1. **Self-awareness** - the ability to read one's emotions and recognize their impact while using gut feelings to guide decisions.
2. **Self-management** - involves controlling one's emotions and impulses and adapting to changing circumstances.
3. **Social awareness** - the ability to sense, understand, and react to others' emotions while comprehending social networks.
4. **Relationship management** - the ability to inspire, influence, and develop others while managing conflicts.

An emotionally intelligent person is the one who can understand, use and manage his own and others emotions adequately. An emotionally intelligent person can lead a successful marital life. Emotional intelligence in marital relationships is expressed in two ways such as, establishing an intimate personal relationship with spouse and having a satisfactory sexual life. In order to maintain successful personal relationship, one has to be emotionally stable and at the same time emotionally intelligent. This can be particularly difficult in marital relationship if one partner demands more from the other and of poor interpersonal skills (Goleman, 1995). In order to have successful marital life, and in turn a satisfactory sexual life, couples need to enhance their interpersonal and intra personal skills. This will facilitate them to know their emotions better, to manage their emotions properly, to motivate one self, to persist in the face of frustrations, to recognize emotions in others and superior handling of relationships.

The problems in marital relationship touch on some of our deepest needs - to be loved, feel respected, fear of abandonment or of being emotionally
deprived. In fact, specific issues such as how to discipline children, how often a couple has sex or how much debt and savings a couple feels comfortable with, are not what make or break a marriage, rather, it is how a couple discusses such sore points matters more for the fate of their marriage. Men and women have to overcome their innate gender differences in approaching rocky emotions, simply having reached an agreement about how to disagree is the key to marital survival (Goleman, 1995). Failing this, couples are vulnerable to emotional rifts that eventually can tear their relationship apart. As we can see, these rifts are far more likely to develop if one or both partners have certain deficits in emotional intelligence. Goleman (1998) is reported an overall strategy to make a marriage success i.e., not to concentrate on the specific issues – childrearing, money, housework - that couples fight about, but rather to cultivate a couple’s shared emotional intelligence, thereby improving the chances of working things out. A handful of emotional competencies – mainly being able to calm down (and calm your partner), empathy, and listening well – can help couples to settle their disagreements effectively. Healthy disagreements, the “good fights” that allow a marriage to flourish and which overcome the negativities that, if left to grow, can destroy a marriage. In a forgoing marital relationship partners have to concentrate on two things, one is to maintain and improve their one to one relationship consistently and is to express and handle their emotions appropriately. Difficulties they face in these areas can disturb their marital relationship and in turn give rise to negative emotions and negative automatic thoughts, which in turn disturbs the sexual functioning of the couples.

Emotions have a crucial role to play in the sexual functioning of an individual. A restricted ability to express warm and tender emotions; worries about rejection or criticism by the partner; feelings of low self esteem;
concerns about being dominated by the partner; and inhibitions about
nakedness or displaying one’s body are some of the emotional concerns that
can affect sexual functioning of a person (Nobre and Pinto-Gouveia, 2009;
that sex is a very sensitive impulse and it can be easily disrupted by emotions
such as fear, anger, anxiety, guilt etc. Nobre and Pinto-Gouveia, (2006b)
reported that both men and women with sexual dysfunction endorsed more
negative emotions during sexual activity. Men with sexual dysfunction had
significantly more emotions of sadness, disillusion and fear, and less
pleasure or satisfaction compared to sexually healthy men. Female data
pointed to similar differences, with women with sexual dysfunction reporting
less pleasure and satisfaction, and more sadness, disillusion, guilt, and anger
(Carvalho and Nobre, 2011; Nobre and Pinto-Gouveia, 2006b).

Anxiety about sex and possible consequences of sex is implicated in the
etiology of most of the sexual dysfunction (Masters and Johnson, 1970;
Kaplan, 1974; Heiman, 2002; Kantor, Bilker, Glasser and Margolis, 2002;
Bancroft, 2009; Sarason and Sarson, 2005; Carson, Butcher, Mineka and
Hooley, 2007). Anxiety is being associated with erectile disorder, premature
ejaculation, male and female orgasmic disorder, vaginismus, dyspareunia etc.
(Sadock and Sadock, 2007). However, some of the studies contradict the
models of Masters and Johnson, and Kaplan and suggest that a neutral or even
a facilitative effect of anxiety on both male and female sexual arousal (Barlow,
Sakheim and Beck, 1983; Elliot and O’Donohue, 1997; Hoon, Wincze and
Hoon, 1977; Laan, Everaerd, Van-Aanholt and Rebel, 1993; Nobre and Pinto-
Gouveia, 2006a). Moreover, studies regarding the impact of sympathetic
nervous system (SNS) activation (the physiological component of anxiety)
have consistently indicated a facilitating effect on physiological sexual
arousal, especially in women (Meston and Gorzalka, 1996; Palace, 1995; Palace and Gorzalka, 1990). This pattern is better observed in non-clinical populations compared to clinical samples. Although studies conducted on women with sexual dysfunction confirmed the facilitating effect of anxiety on sexual response (Meston and Gorzalka, 1996; Palace, 1995; Palace and Gorzalka, 1990), whereas research with male clinical samples indicated a reverse pattern (Beck, Barlow, Sakheim and Abrahamson, 1987). One possible explanation for this contradiction relies on the different operational definitions of anxiety used in the male and female studies.

Research consistently suggests that emotions related to depressed affect (sadness, disillusion, lack of pleasure, lack of satisfaction) is negatively related to sexual arousal (Heiman, 1980; Heiman and Rowland, 1983; Koukounas and McCabe, 2001; Meisler and Carey, 1991; Mitchell, DiBartolo, Brown and Barlow, 1998; Rowland, Cooper and Slob, 1996; Nobre and Pinto-Gouveia, 2009). Heiman and Rowland (1983) found that individuals with sexual dysfunction reported significantly less positive affect during exposure to erotica. Similarly, several studies have shown that positive affect and subjective sexual arousal are positively correlated in both men with and without sexual dysfunction during exposure to erotic films (Koukounas and McCabe, 2001; Rowland, Cooper and Heiman, 1995; Rowland, Cooper and Slob, 1996). In a study conducted with sexually functional females Heiman (1980) reported similar results. Moreover, Nobre and Pinto-Gouveia (2006b), in a study on the determinants of male sexual arousal, found that low positive affect during sexual activity is significantly associated with low subjective and physiological sexual arousal. Experimental studies are further supported these findings, showing that manipulated negative affect in sexually functional subjects produced a delay
in subjective sexual arousal (Meisler and Carey, 1991) and a decrease in penile tumescence (Mitchell, DiBartolo, Brown and Barlow, 1998). Bancroft, Janssen, Strong, Carnes, Vukadinovic and Long, (2003) examined the relation between mood and sexuality in men and found that 42% indicated decreased sexual interest when depressed (compared to 9.4% who indicated increased sexual interest), whereas when anxious/stressed, 20.6% indicated increased and 28.3% decreased sexual interest. In general, these data seem to suggest that depressed mood (lack of positive affect) is more strongly associated with sexual response than anxiety states. More recently Nobre and Pinto-Gouveia (2008) noted that sadness and disillusion are negatively associated with sexual arousal in both sexes. On the other hand, pleasure and satisfaction are positively associated with subjective sexual arousal in both men and women.

Nobre and Pinto-Gouveia (2006b), found that emotions usually associated with depressive disorders (lack of positive affect), as opposed to emotions related to anxiety disorders (negative affect), are most strongly associated with sexual dysfunction. The processes underlying the effect of lack of positive emotions (depressed affect) on sexual function are still unknown. However recent research (Nobre and Pinto-Gouveia, 2008; Nobre and Pinto-Gouveia, 2009) indicated that men and women with sexual dysfunction present cognitive patterns similar to the ones observed in depressive disorders (e.g., incompetence schemas, failure anticipation thoughts, catastrophizing negative consequences, lack of positive thoughts) suggests a cognitive-emotional interference similar to the one observed in depression (Beck, 1996). In fact, research on the role of different cognitive dimensions in sexual function based on Beck’s modes model have indicated that men and women with sexual dysfunction activate significantly more
incompetence self-schemas (“I’m incompetent,” “I’m a failure”) whenever they experience an unsuccessful sexual situation. These self-critical schemas, once activated, elicit negative automatic thoughts (failure anticipation thoughts and erection concern thoughts in men, and disengagement thoughts and sexual abuse thoughts in women) that prevent them from focusing on erotic stimuli (lack of erotic thoughts) and promote lack of positive emotions (sadness, disillusion, guilt and lack of pleasure and satisfaction) (Nobre and Pinto-Gouveia, 2006a).

Studies on anger and worry showed that, these emotions have a negative impact on sexual functioning. Bozman and Beck (1991) reported that anger decreased both desire and arousal. Katz and Jardine (1999) tested the relationship between worry as a trait of personality and sexual desire and aversion in a group of male and female students. Results indicated statistically significant correlations (although weak) between a predisposition to worry and sexual aversive behaviors and low sexual desire.

Rowland, Tai and Slob (2003) found that embarrassment and guilt are the most common emotions reported by men with premature ejaculation during their sexual interactions. Fear associated with sex can block natural sexual response in partners. Fears such as fear of failure, fear of losing control, fear of being dominated, fear of the possible consequences of sex etc can make a person sexually dysfunctional (Sarason and Sarason, 2005; Sadock and Sadock, 2007). Nobre and Pinto-Gouveia (2008) found that fear is one of the best predictors of vaginismus; whereas sadness, disillusion, guilt and lack of pleasure and satisfaction are closely associated with hypoactive sexual desire disorder. Masters and Johnson (1970) pointed out that most sexual dysfunctions are due to crippling fears, attitudes and inhibitions concerning sexual behaviour often based on faulty early learning exacerbated by later
aversive experiences. Stresses of various kinds, depressed affect, anger, hostility, marital conflicts and lack of attraction towards partner can affect one’s emotional state and in turn block the natural sexual impulse to take place.

Nobre and Pinto-Gouveia (2008) noted that most women with sexual dysfunction activate incompetence schemas when facing unsuccessful sexual situations. Lack of erotic thoughts and increased attention focus on failure and disengagement thoughts during sexual activity are common in persons with sexual dysfunction. Sexual conservative beliefs seem to be closely related to hypoactive sexual desire disorder and to a certain extent to arousal difficulties in women. Body image beliefs and automatic thoughts focusing on self-body appearance seem to be strongly associated with orgasmic disorder.

Rellini, Vujanovic and Zvolensky (2010) found that emotion dysregulation leads to sexual problems. Emotion dysregulation reflects difficulties in self-regulation of affective states and difficulties in self-control over affect-driven behaviours (Carver, Lawrence and Scheier, 1996; Gross, 1998). Harris, Cherkas, Kato, Heiman and Spector (2008) reported that emotion dysregulation is related to sexual functioning. Rellini, Vujanovic and Zvolensky (2010) proposed that beyond sexual functioning per se, emotion dysregulation is more related to sexual dissatisfaction, defined as a lack of contentment with one’s sexual life. Frizzetti and Iverson (2004) suggested that emotion dysregulation is negatively related to the interpersonal connection with partners. Polusny and Follette (1995) noticed that emotion dysregulation affects partner’s ability to regulate intense sexually based interoceptive cues also (e.g., bodily arousal, physical sensations, affect intensity etc).
An emotionally intelligent couple can understand their sexual feelings and are able to express them efficiently to their partners. An emotionally intelligent person has the ability to regulate his own moods, to control impulses, to delay gratification, and keep away anxiety, fear, guilt, anger, distress etc from swamping up one’s ability to think and disrupt his sexual functioning. Better emotional intelligence enhances satisfactory marital life and sexual functioning. Hence better emotional intelligence is an essential prerequisite for healthy marital and sexual functioning.

**The need of the study**

Sexual dysfunction is recognized as one of the major problem today and in the history of mankind (McCabe and Goldhammer, 2012). It is one of the most awful disorders that affect the sexual functioning of the individual and of the partner, and in turn disturb the relationship between each other (Krishna, Avasthi and Grover, 2011). The introduction of behaviorally oriented sex therapy by Masters and Johnson and the invention of ‘viagra’ is led to a drastic change in the treatment of sexual disorders and the perception of people in the west. As a result, today people are giving more importance to their sexual functioning rather than in the past. But in India, sex is still considered as a tabooed subject and is talked in private (Mathew and Joseph, 2009). Lot of myths and misconceptions reign in Indian culture even today, similar to the scenario prevailed in the 70’s of western society. Hence it is necessary to understand prevailing myths, misconceptions, culturally held beliefs in our culture and its role in the causation of sexual dysfunction. This study is an attempt of such kind to understand the effect of sex knowledge in the sexual functioning of individuals in Indian context.

Research in sexual dysfunction is very limited in India and is still in its infancy stage (Mahajan and Sharma, 2005; Mathew and Joseph, 2009). The few
studies reported from India are limited to the epidemiological factors of sexual dysfunctions based on hospital clinical records. Whereas studies reported on sexual functioning are based on normal subjects in the population. This may be due to the cultural factors in India where sex is regarded as obscene and a matter of private affair. Hence, people are hesitant to talk about it publicly, even to their physicians. It is also noticed that people are diffident and apprehensive to talk about sex even to their partners, and in many occasions they usually avoid to do so (Mathew and Joseph, 2009). Hence it is highly difficult to get data on clinical population individually and is a time consuming affair to conduct sexual research. This situation acts as the hindrance for sexual researches to take place in India. This condition is to be changed and more researches have to be carried out to understand various etiological factors and treatment aspects in Indian context.

This study is an attempt to understand the nature sexual dysfunction in Indian context. It is intended to understand sexual dysfunction in relation to sex knowledge, marital adjustment and emotional intelligence. This study is intended to realize the relationship factors in sexual functioning of the couples. It is planned to assess the importance of couple’s interpersonal relationships, communication styles, conflict resolution skills and adjustment expertise in sexual functioning. This study is intended to find out the role of emotions and cognitions in sexual functioning of the couples. An attempt is also made to understand the effectiveness of a psychotherapeutic model in the management of sexual dysfunctions.