Chapter III

REVIEW OF RECENT STUDIES

This research is particularly oriented to study sexual dysfunction in relations to sex knowledge, marital adjustment and emotional intelligence. This chapter reviews various studies conducted by several eminent authors in the areas of sexual dysfunction, sex knowledge, marital adjustment and emotional intelligence. Review of studies provides an idea about present researches in the area of study. The studies are reviewed and reported based on the following areas such as sexual dysfunctions, sex therapy, sex education, sex knowledge, marital adjustment, marital therapy and emotional intelligence.

Studies on sexual dysfunction
The present section is devoted to reviewing studies related to sexual dysfunctions. Studies on sexual dysfunction mainly its prevalence, etiological factors, cognitive factors, partner interaction, sexual functioning and sexual satisfaction are reported in this section.

This Christensen, Gronbaek, Osler, Pedersen, Graugaard and Frisch (2011) conducted a study to estimate the prevalence of sexual dysfunctions and to identify associated socio demographic factors. Majority of sexually active adults experience sexual difficulties with their partner once in a while, approximately one in nine suffer from frequent sexual difficulties that constitute a threat to their well-being. Overall, 11% of men and 11% of women reported at least one sexual dysfunction in the last year, while another 68% of men and 69 % (67–71%) of women reported infrequent or less severe sexual difficulties. Estimated overall frequencies of sexual
dysfunctions among men are: premature ejaculation (7%), erectile dysfunction (5%), anorgasmia (2%) and dyspareunia (0.1%); among women: lubrication insufficiency (7%), anorgasmia (6%), dyspareunia (3%), and vaginismus (0.4%). Highest frequencies of sexual dysfunction are seen in men above age 60 years and women below age 30 years or above age 50 years. It also revealed that economic hardship in the family are positively associated with sexual dysfunctions, notably among women. Sexual dysfunctions seem to be more common among persons who experience economic hardship in the family.

Reis and Abdo (2010) studied the prevalence of erectile dysfunction using International index of erectile dysfunction and self reported measure of erectile dysfunction. The erectile dysfunction prevalence in the international index of erectile dysfunction is 31.9%, while self-reported erectile dysfunction prevalence is 3.1%. The factors associated to erectile dysfunctions are: professional inactivity, suspected depression and/or anxiety, reduced sexual desire.

Rosen, Shifren, Monz, Odom, Russo and Johannes (2009) investigated the correlates of sexual distress in women with self-reported low sexual desire. The results revealed that 27.5% women are having low desire, had sexual distress with a mean age of 48.6 years, 81% with a current partner. Women without distress are 10 years older on average and 44% had a current partner. Having a partner is strongly related to distress. Other correlates are age, race, current depression, anxiety, lower social functioning, hormonal medication use, urinary incontinence, and concurrent sexual problems (arousal or orgasm). Dissatisfaction with sex life is more common in women with low desire and distress (65%) than in those without distress (20%). The study concluded that age has a curvilinear relationship with distress and the
strongest correlate of sexual distress is having a current partner. Sexual distress and dissatisfaction with sex life are strongly correlated. Distress is higher in women with low sexual desire in a partner relationship.

Kendurkar, Kaur, Agarwal, Singh and Agarwal (2008) investigated the prevailing pattern of sexual dysfunction in the patients attending marriage and sex clinic from 1979 to 2005 in India. Premature ejaculation is the most common complaint and the most commonly diagnosed clinical entity, followed by male erectile problems and culturally induced sexual behaviors such as Dhat syndrome. Sexual activity continues to be strongly influenced by culturally held beliefs. This influence is more troublesome for young and unmarried persons who have not changed over the period. Being more educated, married and from an urban background promotes help-seeking in tertiary care clinics but these findings may be due to selection bias.

Sidi, Midin, WanPuteh and Abdullah (2008) investigated prevalence of orgasmic dysfunction and potential risk factors that may be associated with orgasmic dysfunction among women. The result revealed that prevalence of orgasmic dysfunction in the primary care population is 51.9%. Women with orgasmic dysfunction are 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. The study concluded that women with infrequent sexual intercourse are less likely to be orgasmic.

Nicolosi, Buvat, Glasser, Hartmann, Laumann and Gingell (2006) studied sexual behaviour, sexual dysfunctions and related help seeking behaviour of middle aged and elderly Europeans. The findings reveal that 83% (eighty-three) of percent of men and 66% (sixty six) of women had sexual
intercourse during the year preceding the interview. The sexual dysfunctions most frequently reported are early ejaculation (11%) and erectile dysfunction (8%) in men; and lack of sexual interest (18%), an inability to reach orgasm (13%) and lubrication difficulties (11%) in women. Of the 23% of men and 32% of women who reported sexual dysfunction, 26% had consulted a physician, with considerable between-country differences. Sexual activity is widespread among adult, middle aged and elderly people, but many experience sexual dysfunctions and few seek medical care.

Laumann, Nicolosi, Glasser, Paik, Gingell, Moreira and Wang (2005) conducted an analysis on the GSSAB data (Global Study of Sexual Attitudes and Behaviors) to estimate the prevalence and correlates of sexual problems. The estimates of prevalence of sexual problems are comparable with published values. Prevalence of sexual problems is higher in East Asia and Southeast Asia than in other regions of the world. For women, lack of interest in sex and inability to reach orgasm are the most common sexual problems across the world regions, ranging from 26 to 43% and 18 to 41%, respectively. For men, early ejaculation is the most common problem. Erectile difficulties among men and lubrication difficulties among women are both relatively common and showed similar prevalence across most regions. Age is an important correlate of lubrication difficulties among women and of several sexual problems, including a lack of interest in sex, the inability to reach orgasm, and erectile difficulties among men. Study reaffirmed that sexual difficulties are relatively common among mature adults throughout the world. Sexual problems tend to be more associated with physical health and aging among men than women.

Nicolosi, Glasser, Kim, Marumo and Laumann (2005) examined sexual behaviour, prevalence of sexual dysfunction and related help-seeking
behaviour among middle-aged and elderly people in Asia. Sexual
dysfunction is defined as persistent sexual problems. Across all countries,
82% of men and 64% of women had engaged in sexual intercourse during
the year preceding the interview. Most of the respondents considered
satisfactory sex an essential means of maintaining a relationship. More than
20% of men and 30% of women complained of having at least one sexual
dysfunction, although there are marked variations among the countries. The
sexual dysfunctions most frequently reported are early ejaculation and
erectile dysfunction among men; and a lack of sexual interest, lubrication
difficulties, and an inability to reach orgasm among women. Of those men
and women who are sexually active and reported sexual dysfunctions, 45%
did sought no help or advice and only 21% sought medical care. The study
concluded that men and women in Asian countries continue to show sexual
interest and activity into middle age and beyond. Although sexual
dysfunction is prevalent in this age group, several sociocultural and
economic factors appear to be preventing individuals from seeking medical
help for these problems.

Simons and Carey (2001) reviewed ten years of research that has provided
data regarding the prevalence of sexual dysfunctions. Community samples
indicated a current prevalence of 0%–3% for male orgasmic disorder, 0%–
5% for erectile disorder, and 0%–3% for male hypoactive sexual desire
disorder. Pooling current and 1-year figures provided community prevalence
estimates of 7%–10% for female orgasmic disorder and 4%–5% for
premature ejaculation. Stable community estimates of the current prevalence
of other sexual dysfunctions remain unavailable. Prevalence estimates
obtained from primary care and sexuality clinic samples are characteristically
higher.
Nicolosi, Laumann, Glasser, Moreira, Paik and Gingell (2004) assessed the importance of sex and the prevalence of sexual dysfunction among middle-aged and older adults throughout the world. Increasing life expectancy has been accompanied by improvements in the health of the middle-aged and elderly, but little is known about how this has affected their sexual experience. More than 80% of the men and 65% of the women had sexual intercourse during the past year. The most common dysfunctions are early ejaculation (14%) and erectile difficulties (10%) among the men and a lack of sexual interest (21%), inability to reach orgasm (16%), and lubrication difficulties (16%) among the women. Overall, 28% of the men and 39% of the women said that they are affected by at least one sexual dysfunction. The results of our study indicate that sexual desire and activity are widespread among middle-aged and elderly men and women worldwide and persist into old age. The prevalence of sexual dysfunctions is quite high and tended to increase with age, especially in men. Although differences between countries are noted, this global study revealed some clear and consistent patterns.

Lewis, Fugl-Meyer, Bosch, Fugl-Meyer, Laumann, Lizza and Martin-Morales (2004) examined the epidemiology and risk factors of sexual dysfunction in male and female. The findings revealed that the incidence rate for erectile dysfunction is 25–30 cases per thousand person years and increases with age. There are no parallel data for women’s sexual dysfunctions. The prevalence of sexual dysfunction increases as men and women age; about 40–45% of adult women and 20–30% of adult men have at least one manifest sexual dysfunction. Common risk factor categories associated with sexual dysfunction exist for men and women including: individual general health status, diabetes mellitus, cardiovascular disease, other genitourinary disease, psychiatric/psychological disorders, other
chronic diseases, and socio-demographic conditions. It is noticed that increasing physical activity lowers incidence of erectile dysfunction in males.

Nazareth, Boynton and King (2003) assessed sexual behaviour, prevalence of sexual dysfunction, associations between sexual and psychological problems, help seeking for sexual problems in people attending general practice, and to understand predictors of sexual dysfunction. 22%, men and 40% women received at least one ICD-10 diagnosis of sexual dysfunction, but only 3-4% had an entry relating to sexual problems in their general practice notes. The most common problems are erectile failure and lack or loss of sexual desire in men and lack or loss of sexual desire and failure of orgasmic response in women. Increasing age and being unemployed predicted sexual problems in women, and bisexual orientation, being non-white, and being unemployed are demographic predictors in men. No practice note factors predicted sexual problems in women, but high consulting rate predicted problems in men. The main clinical predictors are poor physical function and dissatisfaction with current sex life in both sexes and higher psychological morbidity in women. When all factors are considered, increasing age, poor physical function, and sexual dissatisfaction, independently predicted an ICD-10 sexual dysfunction diagnosis in women. Being bisexual was the only independent predictor of an ICD-10 diagnosis in men. The study concluded that sexual difficulties are common in people attending general practitioners, and many people are prepared to talk about them with their doctors.

Rosen (2000) in his study reported that Sexual dysfunctions are highly prevalent, affecting about 43% of women and 31% of men. Hypoactive sexual desire disorder has been reported in approximately 30% of women and 15% of men in population-based studies, and is associated with a wide
variety of medical and psychological causes. Sexual arousal disorders, including erectile dysfunction in men and female sexual arousal disorder in women, are found in 10% to 20% of men and women, and is strongly age-related in men. Orgasmic disorder is relatively common in women, affecting about 10% to 15% in community-based studies. In contrast, premature ejaculation is the most common sexual complaint of men, with a reporting rate of approximately 30% in most studies. Finally, sexual pain disorders have been reported in 10% to 15% of women and less than 5% of men. In addition to their widespread prevalence, sexual dysfunctions have been found to impact significantly on interpersonal functioning and overall quality of life in both men and women.

Laumann, Paik and Rosen (1999) assessed the prevalence and risk of experiencing sexual dysfunction across various social groups and examined the determinants and health consequences of these disorders. The results indicated that sexual dysfunction is more prevalent for women (43%) than men (31%) and is associated with various demographic characteristics, including age and educational attainment. Women of different racial groups demonstrate different patterns of sexual dysfunction. Differences among men are not as marked but generally consistent with women. Experience of sexual dysfunction is more likely among women and men with poor physical and emotional health. Moreover, sexual dysfunction is highly associated with negative experiences in sexual relationships and overall well-being. The study revealed that sexual dysfunction is an important public health concern, and emotional problems likely contribute to the experience of these problems.

Dunn, Croft and Hackett (1998) explored the prevalence of sexual problems in the general population, and assessed the use of and need for professional
help for such problems. A third of men (34%) and two-fifths of women (41%)
reported having a current sexual problem. The most common problems
are erectile dysfunction and premature ejaculation in men; in women the
most widely reported problems are vaginal dryness and infrequent orgasm. In
men, the proportion of responders reporting sexual problems increased with
age, but there is no similar trend in women. Of those responders who
reported a sexual problem, 52% said that they would like to receive
professional help for this problem, but only one in ten of these people had
received such help. The study concluded that there is a high level of reported
sexual problems prevalent in the population. The most frequently reported
problems (vaginal dryness, erectile problems) may be amenable to treatment,
and yet few had sought or received help. However, many said that they
would like to receive help. These figures suggest that there may be an
important burden of potentially reversible sexual problems in the general
population.

Read, King and Watson (1997) studied the prevalence and characteristics of
sexual problems in patients attending general practice. Thirty five per cent of
the men reported have some form of specific sexual dysfunction. Premature
ejaculation is identified as the major problem in men, followed by erectile
dysfunction and sexual problems increased with advancing age. The
prevalence of sexual dysfunction in the women is forty two per cent.
Vaginismus is reported as the highest problem followed by Anorgasmia.
General sexual dissatisfaction is more common than specific dysfunction in
male and female; 68 per cent of the women and 75 per cent of the men
reported at least one problem with dissatisfaction, avoidance, infrequency or
non-communication. The large majority of the sample (70 per cent)
considered sexual matters to be an appropriate topic for the GP to discuss.
Despite this, sexual problems are recorded in only 2 per cent of the GP notes. This study confirms the high prevalence of sexual disorders in the population. Many of these problems are concealed from GPs. Predictors in patients' notes could help GPs to detect those patients with more serious problems.

Korfage, Pluijm, Roobol, Dohle, Schroder and Essink-Bot (2009) examined the association and potential mediating factors between erectile dysfunction and mental health in healthy elderly men. Potential mediators between erectile dysfunction and mental health are satisfaction with and importance attached to sex life. Analysis showed that men with erectile dysfunction had significantly lower mental health scores than men without erectile dysfunction. Erectile dysfunction is also associated with the potential mediator “satisfaction with sex life” but not with “importance attached to sex life.” Men with erectile dysfunction are significantly more often dissatisfied with their sex lives. Erectile dysfunction is associated with poorer mental health. Satisfaction with sex life, but not importance attached to sex life, may play a mediating role in this association. These results suggest that if men with erectile dysfunction can be helped to be satisfied with their sex lives despite erectile dysfunction, mental health can be preserved.

Agostini, Netto, Miranda and Figueiredo (2011) studied Erectile dysfunction in association with physical activity level and physical fitness in men. The individuals are evaluated for age, presence of dyslipidemia and smoking and for anthropometric parameters for the characterization of body mass index. This study showed that younger men with higher physical activity and better physical fitness are less likely to suffer from erectile dysfunction. Multivariable analysis through logistic regression showed that age, physical activity and physical fitness are independent variables associated with
erectile dysfunction. This study reinforces the concept that healthy habits have a direct effect on erectile function.

Kantor, Bilker, Glasser, Margolis (2002) investigated the prevalence of concomitant erectile dysfunction and active depression among patients seen in a general medical setting. The prevalence of moderate or complete erectile dysfunction in this sample is 36.4%. The prevalence of current depression 12.1% and the prevalence of concomitant erectile dysfunction and depression is 5.1%. Using logistic regression, the authors found that current depressive symptoms are not associated with moderate or complete erectile dysfunction. Concomitant erectile dysfunction and depression represent a significant public health problem.

Conaglen, O’Connor, McCabe and Conaglen (2011) investigated sexual dysfunction in female partners of men with erectile dysfunction. Using the Female Sexual Function Index (FSFI) for investigating female sexual function, this study is aimed to understand in greater detail what contributes to changes in women's FSFI scores while their partners are taking oral erectile medications for erection problems. Couples are randomized to receive two erectile medications for two 3-month phases, completed questionnaires. FSFI scores are augmented by individual interviews at baseline, 3 and 6 months, in order to better understand what the scores meant in the context of ED medication use. In all, 50% of the women scored <26.5 at baseline; of these 56% recovered by 6 months. A number of ‘dysfunctional’ women recorded low FSFI scores solely as a result of their partner's ED. Overall, 22% are still ‘dysfunctional’ at 6 months, but one third of these appeared ‘functional’ at 3 months. A further group of women continued to record low scores despite reporting much improved sexual satisfaction. The women's interviews elaborate on their FSFI results, with
five themes emerging to provide more clarity about the relative changes seen in a prospective study situation, and potentially in clinical practice contexts. The increasing use of questionnaires to determine sexual function should be supplemented with good clinical interviewing. The interview details explain how FSFI fluctuations occurred and contain clinical implications for research and practice in the area of couple's sexuality.

McCabe, Conaglen, Conaglen and O'Connor (2010) investigated the motivations of females for seeking medical treatment for their partner's erectile dysfunction (ED). There is increasing evidence that partners have a major role in treatment-seeking behavior for men with ED. The themes that emerged from the data centered on the importance of sex in the relationship, with closeness and intimacy frequently being seen as more important than sex. The second major theme related to hopes that females had in relation to the medication, particularly in relation to increasing their partner's confidence and reducing his sexual frustration. Enhancement of the relationship as well as improving the female's own feelings of self-doubt and sexual frustration are also mentioned. The results of this study show the multi-faceted nature of the motivations that females express in terms of seeking help for their partner's ED.

McCabe and Matic (2008) examined the views of both men with erectile dysfunction (ED) and their partners on the impact of ED on their sexuality, relationship and general functioning. The results demonstrated that both men with ED and their partners reported a reduction in their levels of sexual activity since the development of ED and that they wanted to seek a solution to the problem. Men with ED demonstrated lower levels of self-esteem, quality of life and sexual satisfaction than their partners but there are no differences between the partners in their level of relationship satisfaction.
These findings demonstrate that ED has an impact on both the man and his partner. They also indicate the importance of including the man’s partner in the assessment and treatment of ED.

Conaglen and Conaglen (2008) investigated the impact of erectile dysfunction on female partners. Most of these women recognized the negative effects of ED on themselves, their partners and their relationship. Most of them expressed the view that their sexual satisfaction had declined following the development of their partner’s ED. Self-esteem is lessened for some women, but this is more often due to negative interactions with their partners than from a loss of their sense of womanhood or femininity. The study demonstrated the value of involving the female partner in the treatment process in improving a couple’s sexual satisfaction.

Corona, Bandini, Fisher, Elisa, Boddi, Balercia, Sforza, Forti, Mannucci and Maggi (2010) evaluated the clinical correlates of the perception of partner's sexual desire [Hypoactive Sexual Desire (HSD)] in a consecutive series of subjects seeking medical care for Erectile Dysfunction (ED). Among the patients studied, 19.9% reported a mild loss of their partner's desire, 13.1% a moderate reduction of libido, while 5.1% complained of a complete absence of sexual interest on the part of their partner. After adjustment for confounding factors, the perceived women's HSD is associated with different sexual, lifestyle and relational factors. In particular, more extra-marital affairs, a longer and more hostile couple relationship, as well as a stressful job, and both alcohol and smoking abuse are all significantly associated with perceived women's HSD. In addition, the perceived women's moderate to severe HSD is significantly associated with severe ED and less frequent sexual intercourse. Finally, partner HSD is significantly associated with a stepwise increase of free-floating anxiety and depressive symptoms.
Perceived sexual interest on the part of the woman can be seen for men not only as a fun and enjoyable behavior, but also a safe strategy for improving a man's overall health and life expectancy.

Corona, Mannucci, Petrone, Fisher, Balercia, De Scisciolo, Pizzocaro, Giommi, Chiarini, Forti and Maggi (2005) studied various psycho-biological correlates of delayed ejaculation in male patients with sexual dysfunctions. Delayed ejaculation may be due to the presence of neurological diseases or to the use of serotoninergic drugs. Serotoninergic drugs also significantly increase (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. In conclusion, the present study demonstrates that multiple psychobiological determinants are associated to delayed ejaculation, a still obscure condition that substantially impairs psychosexual equilibrium of the couple.

Robbins-Cherry, Hayter, Wylie and Goldmeier (2011) studied the experience of inhibited ejaculation in five men using qualitative methods. All the men shared some common features that emerged as four major themes. These are sexual development, relationships, fantasy versus reality, and perception of the problem/situation. The participants described low self-esteem and lack of confidence in adolescence. They described a history of unhappy relationships and relationships outside of marriage. Sex in long-term relationships had become mechanical and they are unable to express their sexual needs. Masturbation appeared to be their preferred method of sexual satisfaction.
The study concludes that an integrative approach to therapy is most suited for men living with inhibited ejaculation.

Rowland, Patrick, Rothman and Gagnon (2007) investigated the psychological burden of premature ejaculation. 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. In addition, men with premature ejaculation rated their overall quality of life lower than that of men without premature ejaculation. Consequently premature ejaculation has a significant psychological burden on men, their partners and the male/partner relationship.

Meana, Binik, Khalife and Cohen (1999) investigated psychosocial correlates of pain attributions in women with dyspareunia. Independently of findings from the gynecological examinations, causal attributions are related to adjustment. More specifically, the women who made psychosocial attributions reported higher pain scores, higher levels of psychological distress, lower levels of marital adjustment, more problems with sexual function, and more frequent reports of sexual assault. The relationship between psychosocial causal attributions for pain and psychosocial distress may be clinically useful in the multidisciplinary treatment of this and other pain disorders, regardless of actual physical pathology.

Granot, Zisman-Ilani, Ram, Goldstick and Yovell (2010) explored the relationship among painful experience during sexual intercourse, attachment style, and somatization. The sample included 110 women, 45 of whom reported painful intercourse and are defined as the dyspareunia group, and the remaining 65 were defined as the control group. The dyspareunia group showed greater incidence, compared with the control group, of insecure
attachment styles defined by higher scores of anxiety and/or avoidance as well as higher somatization levels. Regression analyses revealed that increased level of somatization and higher level of avoidance predicted higher probability for dyspareunia. The authors’ findings suggest that women with higher frequency of physical complaints in various body areas and insecure attachment style are more susceptible to report pain during intercourse.

Lourencó, Azevedo and Gouveia (2010) studied the relation between depression and its effect on the sexual desire in psychiatric patients. The obtained results in this exploratory study revealed that depressive symptomatology severity is directly related with sexual desire. Variables gender, age, and working status, as well as, sociocultural levels indicated important and significant differences between patients.

La Rocque and Cioe (2011) examined the relationship between body image and sexual avoidance. Participants are 362 undergraduate students who responded to a battery of questionnaires pertaining to three aspects of body image, sexually avoidant behavior, and three mediator variables, which included sexual esteem, sexual satisfaction, and sexual desire. Consistent with previous studies, a relationship between body image and sexual avoidance is found, indicating that those with a more negative body image displayed a greater tendency to avoid sexual activity. Furthermore, sexual esteem, sexual satisfaction, and sexual desire appeared to mediate this relationship. Implications of these results suggest that these mediator variables are important in the relationship between body image and sexual avoidance, and may be useful targets for those seeking treatment for sexual avoidance issues.
Meuleman (2011) in his study provides an overview of the current literature on the impact of the metabolic syndrome on male sexual health and current developments in the management of sexually dysfunctional men with a metabolic syndrome. The increasing prevalence across the world of the metabolic syndrome—a cluster of cardiovascular disease risk factors—causes the metabolic syndrome to be considered the most important threat to male sexual health of the 21st century. It is reported to have a negative impact on male sexual function through its relationship with cardiovascular disease risk, its association with hypogonadism, and associated psychosocial factors. Besides established pharmacological and hormonal interventions, lifestyle modification programs are considered important therapeutic tools.

Giraldi and Kristensen (2010) studied sexual dysfunction in women with Diabetes Mellitus (DM). DM is considered as a risk factor for sexual dysfunction in men and women, although the evidence in women is less clear. This review attempts to give an overview of female sexual dysfunction in women with DM. Although women with DM are at higher risk of developing sexual dysfunction than women without DM, there is great variability in results across studies, with the incidence of sexual dysfunction in women with DM generally linked less to organic factors and more to psychological factors, especially coexisting depression. This review hypothesizes several presumed causes for such variation in findings across studies and uses these explanations as the basis for a discussion of differences between men's and women's sexuality.

Olsson, Uttaro, Carson and Tafesse (2005) studied prevalence and clinical correlates of sexual dysfunction in a sample of adult male outpatients with schizophrenia treated with olanzapine, risperidone, quetiapine or haloperidol, focusing on associations between sexual dysfunction and patient-perceived
quality of life. Sexual dysfunction occurred in 45.3% of patients. Patients with and without sexual dysfunction did not significantly differ with respect to severity of psychiatric symptoms. However, as compared with patients without sexual dysfunction, patients with sexual dysfunction reported significantly lower ratings on global quality of life and the level of enjoyment in their life. Patients with sexual dysfunction are significantly less likely than those without sexual dysfunction to report having a romantic partner, though they are not significantly less likely to report difficulty making friends. Among patients with romantic partners, those with sexual dysfunction reported significantly poorer quality of their relationships and are less likely to talk to their partner about their illness. The study concluded that sexual dysfunction is common in men with schizophrenia who are treated with olanzapine, risperidone, quetiapine, or haloperidol and is associated with diminished quality of life, decreased occurrence of romantic relationships, and reduced intimacy when relationships are established. High prevalence and substantial interference with quality of life combine to make sexual dysfunction an important area for clinical assessment and appropriate intervention in the community management of schizophrenia.

Frohlich and Meston (2005) examined the relationship between tactile sensitivity in women and sexual arousal disorder. The study revealed that tactile sensitivity is associated with sexual arousal and alterations in tactile sensitivity can impact sexual function. Finger threshold is significantly associated with presence or absence of female sexual arousal disorder and with severity of female sexual arousal disorder.

Blazquez, Alegre and Ruiz (2009) noted that fatigue can affect sexual functioning of an individual, whereas chronic fatigue can lead to sexual
dysfunction. It is noted that chronic fatigue syndrome has direct influence on hypoactive sexual desire disorder.

Hinchliff and Gott (2004) investigated the ways in which age can mediate the impact of sexual health problems on psychological well-being. Participants self-defined their sexual health problems, and these included tiredness, erectile dysfunction and menopause. Older participants reported more physical conditions of a long-term nature and younger participants experienced more short-term problems. The effect these had on the sufferer varied with regard to perceived etiology and longevity of the problem, for instance older participants perceived some problems as age-related which buffered impact on well-being.

Krishna, Avasthi and Grover (2011) attempted to estimate the prevalence and impact of sexual dysfunction on quality of life, treatment compliance, and dyadic adjustment with spouse. For this, 100 consenting subjects who had history of unipolar depression and are in remission at time of intake and met the selection criteria are recruited. Twenty-three subjects are found to have sexual dysfunction. Nine subjects had dysfunction in the domain of desire, 5 had arousal difficulty, 6 subjects had problem with erection, and 8 subjects had problem with orgasm. Some of the subjects (n = 5) had sexual dysfunction in more than 1 domain. Significant difference is found between those with and without sexual dysfunction on dyadic adjustment scale and quality of life scale. However, no significant difference is seen on compliance rating scale and global assessment of functioning scale. From this study, it can be concluded that approximately one fourth of married male subjects experience antidepressant-associated sexual dysfunction. Antidepressant-associated sexual dysfunction contributes to poor quality of life and possibly contributes to poor marital adjustment. Hence, proper
identification and management of sexual dysfunction is important to improve overall outcome of depression.

Chao, Lin, Ma, Lai, Ku, Kuo and Chao (2011) examined the association among sexual desire, sexual satisfaction and quality of life in a sample of community participants. They predicted that quality of life would be positively correlated with sexual satisfaction and that sexual desire would indirectly influence quality of life. This research showed that elderly adults’ sexual desire and sexual satisfaction decrease with age and that nearly 40% of the interviewees still had sexual activity one or more times every month. The results revealed that sexual desire does not directly influence quality of life, but it does have a direct effect on sexual satisfaction; hence, sexual satisfaction will indirectly affect quality of life.

Ventegodt (1998) studied sex and the quality of life. Although sexual problems are found in all age groups, lack of a suitable sex partner and inability to achieve orgasm are more common among the young, and erectile dysfunction more common among the old. Most frequent problems among the women are reduced sexual desire (11.2%) and the lack of a suitable sex partner (4.9%), and among the men, the lack of a suitable sex partner (7.3%) and erectile dysfunction (5.4%). The quality of life of persons with sexual problems is from 1.2 to 19.1% lower than the population mean (as expressed in terms of this mean). The intermediate sized co-variation between sexual problems and the quality of life suggests that such problems can be symptoms of a reduced quality of life rather than a medical problem.

Timm and Keiley (2011) examined the relations among differentiation of self, adult attachment, sexual communication, sexual satisfaction and marital satisfaction in a path analysis model. The path analysis results indicated that
(a) differentiation of self had no direct effect on marital or sexual satisfaction, although it is significantly related to sexual communication; (b) adult attachment had a direct effect on marital satisfaction, but not on sexual satisfaction; (c) sexual communication is a mediating variable; (d) sexual communication is positively related to sexual satisfaction and marital satisfaction; and (e) no gender differences existed in the model.

Carpenter, Nathanson and Kim (2009) studied gender and sexual satisfaction in midlife. The study found the factors contributing to sexual satisfaction to be more numerous and complex for women than for men. Contrary to popular assumptions, bodily sexual practices appeared to be better predictors of physical and emotional satisfaction for women than relational factors, whereas for men, relational factors seemed to be better predictors of both types of satisfaction. As anticipated, physical and emotional sexual satisfaction are influenced by somewhat different factors, but not always in the way commonsense assumptions would predict. Although women expressed less physical and emotional satisfaction with advancing years, while men reported greater emotional satisfaction at older ages, these age effects became non-significant when generation is added to the models. Lower levels of sexual satisfaction at older ages appeared to stem from differences between the Baby Boom and older generations rather than from aging per se.

King, Marumo, Paick, Zhang, Shah, Pangkahila, Yip, Jiann and Ong (2011) examined satisfaction with sex and erection hardness. The Asia-Pacific Sexual Health and Overall Wellness (AP SHOW) survey assessed sexual satisfaction and health and the association with erection hardness in 13 Asia-Pacific countries/regions. Of 3957 (men, n=2016 and women, n=1941) respondents, 41% of men and 34% of women are completely or very
satisfied with sex. Satisfaction with sex is linked to satisfaction with life priorities and overall health. Few respondents (men, 38% and women, 26%) are very or completely satisfied with erection hardness. Optimal erection hardness is reported by 45% of men (48% of women regarding their partners’ erections). Erection hardness is associated with increased frequency of sex and importance of and satisfaction with erection-related elements of men’s sexual performance. Approximately half of respondents (men, 57% and women, 47%) are at least moderately interested in improving the sexual experience. Most Asia-Pacific respondents are less satisfied with sex. Satisfaction with sex is associated with satisfaction with life priorities. Erection hardness is associated with sexual satisfaction and activity, satisfaction with life priorities and overall health.

Smith, Lyons, Ferris, Richters, Pitts, Shelley and Simpson (2010) examined sexual and relationship satisfaction among heterosexual men and women with regard to the frequency of sex. Little is known of the extent to which heterosexual couples are satisfied with their current frequency of sex and the degree to which this predicts overall sexual and relationship satisfaction. Only 46% of men and 58% of women are satisfied with their current frequency of sex. Dissatisfied men are overwhelmingly likely to desire sex more frequently; among dissatisfied women, only two thirds wanted sex more frequently. Age is a significant factor but only for men, with those aged 35–44 years tending to be least satisfied. Men and women who are dissatisfied with their frequency of sex are also more likely to express overall lower sexual and relationship satisfaction. The authors’ findings not only highlight desired frequency of sex as a major factor in satisfaction, but also reveal important gender and other socio-demographic differences that need to be taken into account by researchers and therapists seeking to understand
and improve sexual and relationship satisfaction among heterosexual couples. Other issues such as length of time spent having sex and practices engaged in may also be relevant, particularly for women.

McCabe and Goldhammer (2012) examined demographic, psychological, and relationship factors that are associated with the experience of sexual desire in women. The contribution of other aspects of sexual function on sexual desire is also investigated. The results demonstrated that sexual desire is lower among older, postmenopausal women and those who had been in their current relationship for a longer period of time. Women who reported that their partner experienced a sexual dysfunction also obtained lower sexual desire scores. These findings demonstrate the strong interrelationship between the different phases of the sexual response cycle for women. Further, they suggest that sexual dysfunction in one partner is likely to be associated with sexual dysfunction in the other partner.

Deeks and McCabe (2001) investigated age, menopausal status and the male partner's sexual function on the sexual function of the menopausal woman. The study revealed that sexual satisfaction within the relationship is better predicted by age group. Younger women are more likely to be satisfied with their sexual relationship than older women. Age group is also a better predictor for the current frequency of intercourse. Age group also appeared to be a better predictor of whether the male partner had experienced a sexual dysfunction. Women who are menopausal are more likely to report a sexual problem such as lack of sexual interest, poor lubrication and failure to have an orgasm. The findings of this study indicate that age and the sexual function of the partner are important factors to take into consideration when investigating the sexual function of the menopausal woman.
Woody and D'Souza (1997) studied sexual interaction and sexual functioning in couples. On sexual functioning, attitudinal set, nonsexual interaction, interaction coordination and in post-sexual interaction factors, the non-clinical sample scored significantly better than persons in therapy for sexual dysfunction. Normal partners also reported satisfactory relationship adjustment and a high level of sexual satisfaction, both of which strongly correlated with sexual interaction. Demographic and lifestyle variables, except female health, are not associated with the quality of sexual interaction. Females had lower scores on sexual functioning, nonsexual interaction, and interaction coordination than their male partners, but no gender differences are found in sexual satisfaction and relationship adjustment.

Davis and Reissing (2007) studied the relationship adjustment and dyadic interaction in couples with sexual pain disorders. The findings revealed that sexual pain and penetration problems are foremost an interpersonal, intimate experience, and partner’s interaction and adjustment plays major role in causation of dyspareunia and vaginismus.

Dennerstein, Hayes, Sand and Lehert (2009) investigated association between sexual interest and attitude toward and frequency of partner interaction in women with reduced sexual desire. A high percentage of participants reported that their sexual interest is absent to very weak (45%) or somewhat weak (43%). Those have inadequate partner interaction showed lower sexual interest and attitudes. Higher reported 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.
Due to the growing interest of marital adjustment in sexual functioning, Balon (2010) proposed a new diagnostic concept of adjustment disorder with disturbed sexual functioning. This concept would allow to confer a diagnosis on sexual dysfunctions in response to an identifiable stressor, such as marital or partnership discord, within 1 or 3 months. The disturbance would have to be clinically significant as evidenced by either distress in excess of what one would expect from the exposure, or by significant impairment in social, occupational or interpersonal functioning. According to him the concept of adjustment disorder covers quite a wide area of depression, anxiety, emotions and behavior. So, there seems to be no reason not to use the concept of adjustment disorder for disturbances of states/behaviors/functions other than mood, anxiety, or conduct/behavior, such as sexual functioning. Above all, the proposed concept of “adjustment disorder with disturbance of sexual functioning” answers the issue of clinical utility and practicality.

Purdon and Watson (2011) in their study sought to replicate and extend investigation of current models of sexual dysfunction which implicate factors such as spectating, failure to use ameliorative strategies, and information processing biases in the development and persistence of sexual difficulties. A sample of undergraduates completed measures of sexual dysfunction and relationship satisfaction, and reported on the content and frequency of non-erotic thoughts during sex with a partner (i.e., spectating), the emotional impact of non-erotic thoughts, and the strategies used to manage them. They also reported on their main sexual functioning difficulties and the strategies they used to manage those difficulties. Finally, participants are presented with a series of hypothetical sexual scenarios and are asked to report their immediate interpretation of events in the scenario. Study revealed that greater frequency of non-erotic thoughts, and anxiety evoked by non-erotic
thoughts is associated with poorer sexual functioning, but they found that this is over and above relationship satisfaction. Participants of both high and low in sexual functioning reported using a variety of strategies to manage their non-erotic thoughts, thought suppression being the least effective, and also used a variety of strategies to manage sexual difficulties. Poorer sexual functioning is associated with more negative interpretations of ambiguous sexual scenarios, but this is mediated by relationship satisfaction. However, positive interpretations are predicted by sexual functioning. Results are discussed in terms of their theoretical and clinical implications.

Studies on sex therapy
This section is devoted to the studies related to sex therapy. Studies on behaviorally oriented sex therapy, cognitive therapy, drug only vs. combined treatment approach etc are reported.

LoFrisco (2011) studied effectiveness of cognitive behavioral therapy in female sexual pain disorders. Female sexual pain disorders are prevalent and have a deleterious effect on women's well-being. Because there are psychological elements to this pain, cognitive–behavioral therapy (CBT) may be a viable treatment alternative, particularly when compared to more physically invasive treatments such as surgery or medication. This article provides a critical analysis of research studies in this area by evaluating each study in detail, identifying gaps in the research base, and providing directions for future study. For the most part, all of the studies reviewed in this article found CBT to be effective. However, CBT modalities with minimal therapist direction or interaction are found to be problematic.

Bergeron, Morin and Lord (2010) integrated pelvic floor rehabilitation and cognitive-behavioural therapy for sexual pain. The sexual pain disorders
dyspareunia and vaginismus are highly prevalent yet misunderstood women's sexual health problems. They have proposed the adoption of a treatment approach integrating pelvic floor rehabilitation and cognitive-behavioral therapy in order to target the multidimensional aspects of these complex conditions. They have introduced this model in 2003; the present paper focuses on the progress that has been achieved since then, with an emphasis on the pelvic floor musculature and psychological factors. Growing evidence indicates that pelvic floor rehabilitation and cognitive-behavioral therapy lead to significant improvements in pain and sexual functioning, although there are still only a handful of published randomized controlled trials and only one study focusing on the integration of these two modalities. Recent advances concerning the role of the pelvic floor as well as cognitive and affective variables in the etiology of sexual pain are reviewed, with results showing that higher levels of anxiety, fear of pain, hyper vigilance and catastrophizing, in addition to lower levels of self-efficacy, may contribute to the exacerbation of pain and associated sexual dysfunction.

McCabe (2001) evaluated the effectiveness of a cognitive behavioral program for the treatment of sexual dysfunction. The results demonstrated that, after therapy, respondents experienced lower levels of sexual dysfunction, more positive attitudes toward sex, perceptions that sex is more enjoyable, fewer affected aspects of sexual dysfunction in their relationship, and a lower likelihood of perceiving themselves as a sexual failure. The study proved that cognitive behaviour therapy is effective in the treatment of sexual dysfunction.

Trudel, Boyer, Villeneuve, Anderson, Pilon and Bounader (2008) examined the effects of a group preventive intervention on the marital and sexual functioning of retired couples. The intervention consisted of the Marital Life
and Aging Well Program which seeks to enhance three fundamental aspects of the sexual and marital life of older people using cognitive-behavioral techniques, namely, communication, problem solving, and sexual and non-sexual intimacy. Results indicate an improvement in marital and sexual functioning on most of the measures used. Though a certain deterioration is observed at 3-month and 1-year follow-up, most of the measures nevertheless indicate an improvement in functioning compared with baseline levels. The study indicates that it is possible to optimize functioning of couples entering retirement.

Aubin, Heiman, Berger, Murallo and Yung-wen (2009) examined the effectiveness of a drug only vs. combined treatment approach on erectile function as well as other domains of sexual function and cognition, couple intimacy and adaptation, and treatment satisfaction. The findings of the study extend previous conclusions and provide empirical support for the effectiveness and satisfaction with the combined treatment approach for treating men with erectile dysfunction of mixed etiology.

Bancroft (2009) examined the importance of sex therapy after the impact of “Viagra phenomenon.”. Whereas Viagra and other PD-5 inhibitors provide a method of improving erectile function, it has become increasingly apparent that such pharmacological treatment on its own is often ineffective in the longer term, and needs to be integrated with counseling or psychotherapy to help the couple to incorporate the pharmacological effect into their sexual relationship.

Avasthi, Sharan and Nehra (2003) reviewed selection, outcome and dropout of practicing behavioral sex therapy in India. The study revealed that high income, married status, presence of partner at evaluation and liberal attitude
towards sexuality increased the chances of selection for behavioral sex therapy. The outcome of therapy is associated with treatment adherence. Participation of the conjoint unit resulted in lower dropout rates.

Van Lankveld, Everaerd and Grotjohann (2001) studied the effectiveness of cognitive-behavioral bibliotherapy for sexual dysfunctions in heterosexual couples. After a 10 – week treatment participants reported fewer complaints of low frequency of sexual interaction and general improvement of their sexual problem, and lower male post treatment ratings of problem associated distress. Female participants with vaginismus post treatment reported less complaints of vaginismus. However, female participants with dyspareunia reported more complaints of vaginal discomfort. Both male and female participants reported improvement of their sexual functioning both at post treatment and follow-up, compared to controls.

Wylie (1997) studied the treatment outcome of brief combined sex and relationship therapy for male erectile disorder. Results suggest that behavioral-systems couple therapy and modified modern sex therapy offer a brief, flexible, and reproducible treatment option for men with psychogenic factors associated with erectile disorder.

McCarthy and Thesrump (2008) presented a therapeutic work integrating sex therapy interventions with couple therapy. It presented a couple, integrative, psycho biosocial model of assessment, treatment and relapse prevention for common sexual dysfunctions. This model can encourage couple therapists to integrate sexual permission-giving, scientifically and clinically relevant sexual information and guidelines, and specific sexual suggestions/interventions into their couple work.
Hatzichristou, Rosen, Broderick, Clayton, Cuzin, Derogatis, Litwin, Meuleman, O’Leary, Quirk, Sadowsky and Seftel (2004) studied clinical evaluation and management strategies of sexual dysfunction in men and women. The findings revealed that three concepts underlie sexual medicine management: (i) adoption of a patient-centered framework for evaluation and treatment; (ii) application of the principles of evidence-based medicine in diagnostic and treatment planning; and (iii) use of a unified management approach in men and women. When taken together, these three principles provide a balanced and integrated approach to sexual dysfunction management.

Herbenick, Reece, Sanders, Dodge, Ghassemi and Fortenberry (2010) reported that vibrator use is associated with positive sexual function. They studied 2056 women aged 18–60 years in the United States about women’s use of vibrators within sexual partnerships. Most vibrator users indicated comfort using them with a partner and vibrator use is related to positive sexual function as measured by the Female Sexual Function Index (FSFI). In addition, partner knowledge and perceived liking of vibrator use is a significant predictor of sexual satisfaction for heterosexual women.

Brotto, Mehak and Kit (2009) researched on yoga and sexual functioning. The study revealed that yoga has a positive influence on the sexual functioning of the individual. They found that yoga can enhance the sexual functioning.

Rosenbeaum (2011) studied in-vivo in physiotherapy treatment of women with severe vaginismus. This article describes a therapeutic intervention designed to help women with vaginismus to prepare for examination and treatment by addressing the component of anxiety in real-life situations. This
approach is also appropriate for nurse practitioners and physicians who work with this patient population and may be adapted for sex therapists to teach as a home exercise. Physiotherapy for the treatment of vaginismus is perceived as an intervention aimed to normalize muscle tone of the pelvic floor in order to allow vaginal penetration.

McCabe and Price (2009) examined the dropout rate from an internet based treatment program for erectile dysfunction (ED), and determined reasons for attrition from this program. These reasons included medical conditions that contributed to their ED, the man’s partner not being interested in participating in the program, a lack of motivation from the man, or the time commitment being too demanding. Whereas, the dropout from medical treatment is also high, but this may be due to the lack of focus on individual and interpersonal factors that may have caused or maintained the problem. This finding may be explained by the fact that during face-to-face therapy, the therapist has an opportunity within the session to address factors that may be inhibiting motivation to participate in treatment, such as ambivalence to change, lack of confidence in the treatment, or limited enthusiasm. The opportunity for the therapist to address factors affecting motivation is more limited during internet-based treatment.

**Studies on sex education**

This section is devoted to studies related to sex education. Studies which highlights the importance of sex education, sex education programs for newly marital couples and for the youth are reported.

Farnam, Pakgohar, Mirmohamadali and Mahmoodi (2008) conducted a study to evaluate the effect of a special sex education program in sexual health on Iranian newly-wed couples. Sex education consisted of different aspects of
sexuality such as, reproductive and sexual health, the sexual response cycle and sexual communication are imparted to study group. The results indicate that the sexual health in the study group is significantly improved compared with the control group.

Sousa, Soares and Vilar (2007) conducted a study to understand the effectiveness of sex education program in youth. The sex education program resulted in more positive attitude towards sex and improvement in their knowledge regarding sex. The participants of the sex education program show a multi-oriented style of sexual information and, at a behavioural level, they refer more frequently to the use of safe methods for preventing sexually transmitted diseases.

Shirpak, Ardebili, Mohammad, Maticka-Tyndale, Chinichian, Ramenzankhani and Fotouhi (2007) studied the efficacy of the sex education program for female clients of health centers in Iran. The program demonstrated a statistically significant impact on knowledge and attitudes of the participants. There is also a statistically significant change in intentions and behavior. This study showed that even in societies where people’s religious and cultural background, and strict rules might seem to make sexual education an impossible task, choosing the location and target population based on cultural norms, and the educational content based on the target group’s needs and cultural and religious background, can pave the road to success.

Lindau, Goodrich, Leitsch, and Cook (2008) studied the effect of a multi-modal curricular intervention designed to teach sexual history-taking skills to medical students. A significant positive association is found between the curricular intervention and the number of screening sexual history questions asked. Under conditions of a general clinical skills evaluation, the
intervention significantly improved medical students’ sexual history-taking skills.

Cok and Gray (2007) studied the development of a sex education program for 12-year-old to 14-year old Turkish adolescents. The sex education program consisted of eight sessions and the following units are presented: human development, relationships, sexual behaviour, sexual health, and society/culture. The program has shown positive results and enabled them to learn more about sexuality.

Studies on sex knowledge

This section is devoted to the studies on sex knowledge. It reviews studies regarding the importance of adequate knowledge about sex, relation between sex knowledge and sexual functioning, sex knowledge among educated and non-educated, and the prevailing myths and misconceptions in India.

Lyons, Giordano, Manning and Longmore (2011) studied the double standard in sex. The idea of sexual double standard emphasizes that men have more sexual freedom, whereas women are subject to social sanctions for the same behaviors. This research uses a sample of adolescent women to examine the social consequences of reporting a greater number of sex partners. The research explores whether there are broader social costs and feelings of low self-worth associated with a high number of sex partners, and also focuses on characteristics of the adolescents' close friends. The analyses of quantitative data provide support for the emphasis on the adolescents' immediate network of friends: Friends' attitudes and behaviors are significant predictors of respondents' own sexual experiences, while those reporting a higher number of sex partners did not report a lack of popularity, desire for more friends, or lower self-esteem. Women often recognized the existence of
a double standard on a societal or school level, but support or acceptance provided by the more immediate network of similarly situated friends serves as a buffer against such negative attributions. The findings suggest that programs targeting sexual behaviors should focus on how peer norms influence girls’ sexual choices.

Gott, Galena, Hinchliff and Elford (2004) conducted a study to identify barriers perceived by general practitioners and practice nurses to inhibit discussion of sexual health issues in primary care and explore strategies to improve communication in this area. The study identified various barriers in discussing sexual health are patients of the opposite gender, patients from black and ethnic minority groups, middle-aged and older patients, and non-heterosexual patients. Potential strategies to improve communication about sexual health within primary care included training, providing patient information and expanding the role of the practice nurse; however, several limitations to these approaches are identified. The study concluded that general practitioners and practice nurses did not address sexual health issues proactively with patients and many are hesitant to ask direct or indirect questions related to sexuality.

Gott and Hinchliff (2003) studied the barriers experienced by older people in seeking treatment for sexual problems. The results revealed that general practitioners are seen as the main source of professional help if sexual problems are experienced. However, several barriers are identified as inhibiting help being sought. These included the demographic characteristics of the general practitioners, general practitioner’s attitude towards later life sexuality, the attribution of sexual problems to ‘normal ageing’, shame/embarrassment and fear, perceiving sexual problems as ‘not serious’ and lack of knowledge about appropriate services. These findings indicate
that many older people have sexual problems that they would like to discuss with their general practitioners, but they feel unable to do so. General practitioners may need to be more proactive in raising sexual health issues in consultations if these needs are to be met.

Hinchliff & Gott (2011) reviewed literature regarding seeking medical help for sexual concerns in mid and later life. Research consistently reports that older people tend not to seek medical help for sexual concerns or difficulties. This article reviews the literature to examine help-seeking behaviour and doctor–patient interaction of middle and later life age groups for sexual problems in life. Twenty-five articles from 1999 to 2010 are identified and analyzed. Significant barriers to seeking medical help included psychosocial factors relating to the patient, such as thinking that sexual changes are “normal with ageing,” and also to the doctor—for example, assuming that sex was less important to older patients than it was to their younger patients. Inadequate training at medical schools for health care professionals (HCPs) is also identified as a barrier. People are more likely to seek help if their doctor had asked about sexual function during a routine visit sometime during the previous three years. However, doctors tended not to take a proactive approach to sexual health management, and indeed often had limited knowledge of later-life sexuality issues. There are clear implications for sexual well-being if the doctor does not ask and the patient does not tell. Providing education about later-life sexuality for HCPs is crucial if we are to meet the needs of older patients in useful and effective ways.

McKelvey, Webb, Baldassar, Robinson and Riley (2002) studied the relationship between background and socio demographic variables, attitude toward controversial aspects of human sexuality and sex knowledge among medical and nursing students. A significant relationship is found between
certain background and socio demographic variables, sexual attitudes and sex knowledge. The background variable most strongly related to both attitude and knowledge is frequency of attendance at religious services of any religious denomination during the past month. Those who attend religious services more frequently (three or more times) are more likely to express negative attitude regarding sexuality and also have lower sex knowledge scores. Lower sex knowledge is related to negative attitude towards gay/lesbian/bisexual behaviour, masturbation, premarital sex and contraception. Other important background and socio demographic variables related to negative attitude are, never having experienced sexual intercourse, right-wing political orientation, lower family income, gender and ethnicity. The study concluded that negative attitude toward controversial aspects of human sexuality and lower sex knowledge scores can be predicted on the basis of background and socio demographic variables. Education aimed at increasing sex knowledge and modifying negative attitude may enhance individuals’ sexual functioning.

Westwood and Mullan (2007) assessed the sexual health knowledge of teachers who contribute to secondary school sexual health education. The results suggested that teachers have insufficient sexual health knowledge to effectively teach many aspects of sexuality, sexually transmitted infections and emergency contraception methods. There are no statistically significant differences in the results regarding location of school, area of residence, gender or age of the participant. The study throws light in to the fact that those who are expected to impart sex education in schools do not have sufficient knowledge to provide young people with adequate sexual health education. As a result, in many cases they would prefer not to teach, these
programs. It indicates that irrespective of profession and education poor sex knowledge is present in many persons.

Hyde, Carney, Drennan, Butler, Lohan and Howlett (2010) examined how parents communicate with their children about sexuality. Findings indicated that while parents tended to pride themselves on the culture of openness to sexuality that prevailed in their home, they often described situations where very little dialogue on the subject actually transpired. However, unlike previous research on the topic that identified parent-related factors (such as ignorance or embarrassment) as the main impediments to parent-young person communication about sex, participants in our study identified the central obstacle to be a reticence on the part of the young person to engage in such dialogue. Participants described various blocking techniques apparently used by the young people, including claims to have full prior knowledge on the issue, physically absenting themselves from the situation, becoming irritated or annoyed, or ridiculing parent’s educational efforts.

Mahajan and Sharma (2005) studied the attitude of parents towards imparting sex education for their children in India. Results of the study revealed that mothers are reluctant to talk about sexuality to their daughter as they found it embarrassing to discuss these issues. Generally, they avoid any mention to 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 the parents themselves lack scientific knowledge about it. Adolescents need to be taught about this topic since ignorance perpetuates myths and misbelief.

Measor (2004) studied adolescent’s view of sex education and adolescent sexuality. The study revealed that adolescents had different access to
information about sex and sexuality, but the sources of information have an impact on their life. Sources of information and counselling about sexuality varied with gender. Boys and girls are exposed to different kinds of experience, in which information about sexuality and messages about desire also vary. Home and intimacy with parents, especially mothers, is an important influencing factor for girls, but not for boys. This indicates that boy’s learning about sex and sexuality in ways that by and large do not include adults or more especially trusted adults, and there appears to be some elements of exclusion from the family. This has important implications for sex education programs, and it offers insights into why the boys resist school sex education work.

Kang and Quine (2008) carried out a novel qualitative study that identified the concerns of young people about sex. The findings suggest that young people have a wide range of concerns, many of which are very explicit. An important finding is the high proportion of questions related to concerns over relationships. The four categories thus identified are sexual development, sexual and reproductive health, sexual relationship issues and sexual practices. The study stressed the need for a broader approach to sex education.

Khan, Hudson-Rodd, Sagger, Bhuiyan, Bhuiya, Karim and Rauyajin (2008) studied men’s sexual health concerns in Bangladesh. It is revealed that without adequate knowledge of human sexuality, men deem ‘sex’ as another agency of power, dominance and governance. Sexual performance with a large-sized penis symbolizes masculine power to control women. Narrowly focused penetrative male sexuality relies 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’. 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.

Bhan, Mahajan and Sondhi (2004) studied sex knowledge among adolescent girls in Punjab. The results of the study revealed that girls had poor level of sex knowledge. They are also hesitant to talk about sex topics. A matter of serious concern is a fact that students had no reliable means of obtaining correct information. Schools are inadequately equipped to meet the challenge. So they should be provided with unbiased, unmoralistic information so that they are better informed and better adjusted to their changing physical, biological and emotional needs.

McMillan (2004) examined the need of sexual knowledge program in China. The study revealed that rapid modernization in China has ‘negative impact’ on marriage and the family, mainly, changes in attitudes to sex and in sexual conduct. The study throws light into the urgent need of the sexual knowledge program which is constructed around a nature narrative, can give an idea about how bodies are sexed, how bodies have sex, and the legitimate forms of their intimate relationships.

Singh, Bankole and Woog (2005) evaluated the need for sex education in developing countries. The study pointed out that young people’s need for sex education is evidenced by their typically early initiation of sexual activity, involuntary context within which they have sexual intercourse, high-risk sexual behaviours etc. The adequate level of sex knowledge is a means of protecting their sexual health. The early of initiation of sexual intercourse has implications for the age by which sexuality education should be provided. The extent and context of sexual behaviour is a firm indicator of
the need for sex education as well as for counseling and other services related to sex and reproductive health.

Mturi and Hennink (2005) conducted a study to identify the views of young people, parents and teachers concerning sex education in Lesotho. Findings show the limited and problematic sources of sex education for adolescents in Lesotho. They also highlight broad support for the introduction of sex education in the national school curriculum among young people, parents and teachers. The study emphasized the need for the development of a sex education curriculum which has balance between providing young people with information regarding sex and developing their skills in sexual empowerment and negotiating sexual pressure. The use of pupil-centered interactive pedagogies is seen as essential. Teachers are to be given training in the delivery of sex education, which includes instruction on course materials, teaching methodologies and developing sensitivity to teaching sexual issues to young people.

Kelly, Worth, Akuani, Kepa, Kupul, Walizopa, Emori, Cangah, Mek, Nosi, Pirpir, Keleba and Siba (2010) studied gendered talk about sex and sexual relationships. It revealed that irrespective of gender, respondents predominately understood sex as being for the sole purpose of reproduction within marriage. When discussing sex and sexual relationships, young men used explicit language and referred specifically to sexual organs and activities, but young women did not. Young men less concerned for privacy, talked in public spaces and in groups with same-sex peers about sex and sexual expression, whereas young women discussed such matters one-to-one and in private. These gender differences provide useful entry points for developing appropriate sex and HIV education program involving young people.
Hirst (2008) studied the effect of school-based sexuality and relationship education. The study revealed that school-based sexuality and relationship education offers one of the most promising means of improving young people’s sexual competence and levels of safer sexual practice. It also supported the view that the design and implementation of these programs warrant high priority if they are to improve the sexual health and well-being of young people.

Brewster and Wylie (2008) presented the need for the development and use of sexually explicit material in sex education within UK psychosexual therapy clinics, medical schools and also in state-maintained secondary schools with reference to interests that have shaped the provision of sex education since the early twentieth century. They pointed out that use of sexually explicit material further help in imparting sex knowledge to clients and students.

Walsh and Ward (2010) investigated connections between magazine reading and young people's sexual health knowledge, self-efficacy, intentions, and contraception use. Study 1 assessed sexual health behaviors and magazine reading among 579 undergraduate students. As expected, more frequent reading of mainstream magazines was associated with greater sexual health knowledge, safe-sex self-efficacy, and consistency of using contraception, although results varied across sex and magazine genre. Study 2 replicated and expanded on these findings with a survey of 422 undergraduate students, incorporating a more extensive knowledge scale, questions about safe-sex intentions, and measures of magazine involvement. Results suggest that magazine use is associated with positive sexual health outcomes among young people.
McFarland, Uecker and Regnerus (2011) assessed the role of religion in influencing sexual frequency and satisfaction among older married adults and sexual activity among older unmarried adults. The study proposes and tests several hypotheses about the relationship between religion and sex among these two groups of older Americans, using nationally representative data from the National Social Life, Health and Aging Project. Results suggest that among married older adults, religion is largely unrelated with sexual frequency and satisfaction, although religious integration in daily life shares a weak, but positive, association with pleasure from sex. For unmarried adults, such religious integration exhibits a negative association with having had sex in the last year among women, but not among men.

Pinquart (2010) based on sexual script theory, assessed ambivalence in the decision to have sexual intercourse for the first time in adolescents. On average, adolescents showed moderate levels of ambivalence. Younger adolescents, students from the highest school track, adolescents with less positive body image, those with higher love attitude, those who did not take the initiative to have intercourse, and those feeling pressured to have sex showed higher levels of ambivalence during their decisions. Higher levels of decisional ambivalence about having intercourse are associated with a later age at the time of first intercourse and with a lower probability of contraceptive use. This study concludes that some levels of ambivalence are common in young people's decisions about having coitus as they have to negotiate contradictory sexual scripts, beliefs and needs.

**Studies on marriage adjustment**

This section is devoted to the studies on marital adjustment. Studies highlights the role of adjustment among couples, interpersonal relationships,
interaction styles, communication skills, problem solving skills etc are reviewed.

Elliott and Umberson (2008) examined how married people understand and experience sex in marriage. Results indicated that married men and women tend to believe that sex is integral to a good marriage and that men are more sexual than women. Moreover, husbands and wives commonly experience conflict around sex and undertake emotion work to manage their own and their spouse’s feelings about sex. Emotion work involves the active management of one’s own emotions and efforts to manage the emotions of others.

Yabiku and Gager (2009) investigated the association between sexual frequency and satisfaction and stability of marriage. The findings revealed that lower frequency of sexual activity is associated with decreased sexual and marital satisfaction and higher rates of divorce. Among the cohabiters and married people study reveals that low sexual frequency is associated with significantly higher rates of union dissolution among cohabiters than married couples.

Peleg (2008) investigated the relationship between differentiation of self and marital satisfaction. The four factors of differentiation of self based on family system theory such as emotional reactivity, emotional cutoff, fusion with others and the ability to take an I-position are assessed. Marital satisfaction is found to be inversely correlated with emotional cutoff, so that lower cutoff is associated with greater satisfaction. An interesting gender finding is that satisfaction is connected to emotional reactivity, emotional cutoff and I-position among men, but only related to emotional cutoff among women. Another gender difference is that level of marital satisfaction and
duration of the marriage are negatively correlated for women and positively correlated for men. Results suggest that a crucial balance of separation and closeness provides an optimal context for meeting the needs of spouses and promoting the healthy development of marital life.

Ahmad and Reid (2008) explored the ways in which adherence to traditional marital expectations in one’s marriage is related to styles of interpersonal listening and marital satisfaction. Results indicated that greater adherence to traditional marital beliefs are correlated with lower levels of interpersonal listening and marital satisfaction. However, closer examination of the traditional orientation subscales revealed that expectation of traditional husband and wife roles did not result in lower empathic listening in one’s marriage or lower marital satisfaction, but the lower degree to which one believed in upholding equality in undertaking such traditional roles did. Furthermore, empathic listening mediated the relationship between belief in equality in one’s relationship and marital satisfaction.

Nezhad and Goodarzi (2011) investigated sexual relationship and intimacy among postpartum spouses and the effect of those relationships on their marital satisfaction. Results suggested that there are higher levels of sexual desire reported by husbands and there is a significant positive relationship between sexuality and marital satisfaction, for both genders. Moreover, high intimacy diminished the negative effects of marital satisfaction due to reported low sexual satisfaction. Regarding negative effects of marital dissatisfaction in first-time families, it is important to assess main related issues such as postpartum sexuality and intimacy, to obtain knowledge for health care providers to provide support to the postpartum families.
Miller, Caughlin and Huston (2003) examined the processes that underlie the association between trait expressiveness and marital satisfaction. The results suggested that expressiveness promotes satisfaction by leading spouses to engage in affectionate behavior and by leading them to idealize their partner. Expressive people formed idealized images of their partner because they brought out the best in their partner's behavior and because they interpreted their partner's behavior in a favorable light. The study showed that the benefits of trait expressiveness extend into the second decade of marriage and by providing a plausible explanation of the connections between trait expressiveness and marital satisfaction.

Sacco and Phares (2001) examined whether people are more maritally satisfied when the valence of their partner's view of them is congruent with the valence of their self-view. Regardless of self-esteem and depression level and across trait categories, people are more maritally satisfied when their partners viewed them positively and less satisfied when their partners viewed them negatively. The findings of the study are inconsistent with self-verification theory and consistent with a self-esteem enhancement model.

Malinen, Kinnunen, Tolvanen, Ronka, Wierda-Boer and Gerris (2010) studied the links between spousal and parent-child relationships. The findings reveal that as higher levels of satisfaction in the spousal relationship are related to higher quality in the parent-child relationship and lower parental role restrictions. These connections did not differ by gender or country. With family typological analyses four family types were identified: families with satisfying relationships (73.4% of the families), families with unsatisfying parent-child relationships (13.4%), and families with either dissatisfied men (6.0%) or dissatisfied women (7.2%).
Traeen (2010) analyzed sexual dissatisfaction in couple relationships. The reasons for sexual dissatisfaction and to what extent dissatisfaction is associated with thoughts of ending the relationship are also studied. The findings revealed that 62% of them are sexually satisfied with their partner, 23% reported neither being satisfied nor dissatisfied, and 15% are dissatisfied. Controlling for gender, age and level of education, sexual dissatisfaction is statistically significantly associated with low frequency of sex and having children below the age of 12 in the household. Women tended to blame the dissatisfaction with their sex life on their own reduced sexual desire. Men regarded too little creativity in their sex life as the primary cause of dissatisfaction. In men, a boring sex life is the most important reason for considering breaking up with their partner. Women’s main reasons for ending the relationship revolved more around arguments with the partner over the division of domestic duties and responsibilities and feeling bored in the relationship.

Rehman, Janssen, Newhouse, Heiman, Holtzworth-Munroe, Fallis and Rafaeli (2011) examined the association between marital satisfaction and communication patterns involving different domains of conflict. The results showed that negative affect displayed during the sexual conflict is significantly more predictive of marital distress than negative affect displayed when discussing a nonsexual conflict. However, there is no difference in the predictive value of positive affective expressions across the two conflict domains. The study pointed out that among newlywed couples, wives are more sensitive to and more affected by sexual conflicts in relationship, as compared to husbands.

Burleson and Denton (1997) studied relationship between communication skills and marital satisfaction. The study proposed that the relationship
between communication skills and marital satisfaction is not simple and straightforward, but rather is quite complex, varying as a function of several moderating factors—skill type, marital distress, gender, and analytic unit (couple, self, or other). Analysis revealed that the magnitude and even the direction of the associations varied as a function of the moderating variables. In particular, skills and satisfaction are positively associated among non-distressed couples, but are negatively associated among distressed couples. The study emphasizes the role of communication in marriage and in the treatment of marital distress.

Klinetob and Smith (1996) examined the demand-withdraw communication dynamic during which one spouse requests change and the other disengages from the topic. The results showed that when wives demanded and husbands withdrew during discussions of her issue, whereas when husbands demanded and wives withdrew during discussions of his issue. Time-series analyses of observational data confirmed that demand and withdraw behaviors are temporally associated during the course of discussion. We classified couples as bidirectional, wife-dominant, husband-dominant and nondependent, based on the pattern of interdependency they exhibited.

Schneewind and Gerhard (2002) explored the relationship between couple’s stable personality variables associated with interpersonal competencies and marital satisfaction with conflict resolution style as the mediating factor. The results indicate strong mediational effects across time. In particular, conflict resolution styles appear to form during the 1st year of marriage and are habituated thereafter to a large extent. The relationship and personality variables correspond closely with conflict resolution styles, which in turn influence marital satisfaction.
Gallo and Smith (2001) examined the association between attachment style and marital functioning, focusing on cognition as a key explanatory link. Attachment style is related to marital adjustment and to attribution style, with anxious attachment being a stronger predictor than avoidant attachment. The interaction of husbands' and wives' attachment styles also predicted marital functioning. In some cases, the tendency to make negative attributions for spouse behavior mediated the effects of attachment style on marital adjustment. The results supported the general hypothesis that adult attachment style predicts functioning in intimate relationships, and suggest that cognitive processes may form part of the path explaining this association.

Toomey (2006) analyzed the verbal sequential processes of high marital adjustment couples and low marital adjustment couples using the Intimate Negotiation Coding System (INCS). The findings indicate that high marital adjustment interaction is primarily characterized by significant sequential patterns of confirming, socio-emotional description, and instrumental questioning strategies. The low marital adjustment interaction is mainly characterized by unique reciprocal patterns of confront-confront, confront-defend, complain-defend, and defend-complain verbal interacts. It is also found that the verbal negotiation processes of low-adjusted marital couples are more highly structured or patterned than the sequential interaction of high-adjusted marital couples.

Bryant and Conger (1999) examined the association between various domains of social network support and the long-term marital success of husbands and wives who had been married for an average of 20 years. They hypothesized that three domains of social network support (e.g., support related specifically to the relationship, affective overlap, and general
personal support) would predict marital success. Overall, the findings suggest that social networks are influential in long-term marital relationships. For both husbands and wives, relationship-specific support predicted positive change in marital success from 1991 to 1994. Neither affective overlap nor personal support predicted marital success. This study underscores the significance of different domains of social support in long-term romantic relationships, the role of social support in predicting marital success, and the role of marital success in predicting social support.

Cohen, Geron and Farchi (2009) studied the relationship between marital quality and global well-being among husbands and wives in enduring marriages. The findings indicate that, while the husband’s marital satisfaction is dependant largely on the content of the marital relationship and not related to their general well-being, the wife’s marital satisfaction is affected by both the content of their marriage and their global well-being and, moreover, contributed to their well-being. These findings are consistent with Bernard’s contention that marital quality is more important to wife’s mental health than to husbands.

Soons and Liefbroer (2009) examined how relationship transitions affect subjective well-being (SWB) and how this effect changes over time. The result showed that dating, unmarried cohabitation, and marriage had additional well-being enhancing effects. After entry into a union, well-being slowly decreased. A large subjective well-being decrease is found after union dissolution, but through adaptation or repartnering well-being increased again. Well-being of never-married and never cohabiting young adults decreased slowly over time. These effects are independent of parenthood and employment.
Skowron (2000) in his study examined the relationship between differentiation of self and quality of marital relationships. Couple’s levels of differentiation explained substantial variance in marital adjustment: 74% of variance in husband marital adjustment scores and 61% of variance in wife marital adjustment scores are accounted by couple differentiation of self-scores. Greater husband emotional cutoff uniquely accounted for husband and wife marital discord. Contrary to family systems theory, actual couples are no more similar on differentiation than are randomly matched couples. Finally, greater complementarities among couples along the specific dimensions of emotional cutoff and emotional reactivity predicted greater marital distress.

Trudel, Villeneuve Preville Bover and Frechette (2010) studied dyadic adjustment, sexuality and psychological distress older among couples. Results indicate that dyadic adjustment, sexual satisfaction and gender predict psychological distress and explain 14.2% of the variance of psychological distress among older couples. The same predictor variables are found in men and women separately. Moreover, participants with low marital functioning show more than twice psychological distress and poorer sexual functioning.

Hashmi, Khurhid and Hassan (2007) explored the relationship between marital adjustment, stress and depression. Results indicated highly significant relationship between marital adjustment, depression and stress. The working married women have to face more problems in their married life as compared to non-working married women. Highly educated working and non-working married women can perform well in their married life and they are free from depression as compared to educated working and non-working married women.
Ulla and Taru (2004) investigated the relationship between economic stress and marital adjustment. The study revealed the path by which economic circumstances are linked to marital adjustment, such as poor economic circumstances are linked to economic strain, which is related to increased psychological distress, and psychological distress in turn is negatively reflected in marital adjustment. However, psychological distress only partially mediated the link between economic strain and marital adjustment. Economic strain is also directly linked to decreased marital adjustment. In addition, there occurred crossover between partner’s experiences. First, wife’s psychological distress is negatively related to husband’s reports of marital adjustment and vice versa. Second, unemployment among men is directly linked to reports of marital adjustment among women: the longer the man’s total spells of unemployment, the poorer the woman’s marital adjustment.

Lavee and Ben-Ari (2007) examined the association between work related stress of both spouses and daily fluctuations in their affective states and dyadic closeness. The findings indicate that work stress has no direct effect on dyadic closeness but rather is mediated by the spouse’s negative mood. Evidence is found for spillover of stress from work to mood at home, as well as negative crossover among couples with higher marital quality, resulting in greater distance on stressful days. Such increased distance may reflect either a deleterious effect of work stress on marital relationships or a protective mechanism used by couples in times of stress.

Henry and Miller (2004) examined the midlife marital problems and found that issues around values, communication, commitment, decision making, emotional intimacy, and sexual issues are the most destructive to marital satisfaction in midlife couples. The ability of therapists to adequately address
the presenting problems of couples impacts the process and outcome of the 
marital therapy. Validation of couple’s problems will be a building block of a 
strong therapeutic alliance. As therapists are able to form and maintain a 
strong therapeutic alliance, positive treatment outcomes will increase. In 
addition, therapists should be aware and able to deal with problems midlife 
couples often bring into therapy, such as financial issues, ways of dealing 
with children, and sexual issues, to make treatment as effective as possible.

Choi and Marks (2008) examined the relationship between marital conflict, 
depression and functional impairment. The findings indicated that marital 
conflict directly led to increases in depression and functional impairment and 
indirectly led to a rise in depression via functional impairment. Overall, 
findings suggest marital conflict is a significant risk factor for psychological 
and physical health among midlife and older adults.

Kluwer, Heesink and Vliert (1996) studied the relations between time use, 
dissatisfaction, and marital conflict about the division of house-hold labor 
and paid work. Couples experienced more conflict about household labor 
than about paid work. Conflict about household labor is related solely to 
wife’s dissatisfaction with the division of household labor. Conflict about 
paid work revolved around both spouse’s dissatisfaction with the husband’s 
working hours. The majority of spouses preferred husbands to spend less 
time on paid work

Roberts (2000) studied the hostile and distancing behaviors as predictors of 
marital distress. The study examined the relationship between partner hostile 
responsiveness, as well as three types of withdrawing responses (intimacy 
avoidance, conflict avoidance and angry withdrawal) and both concurrent 
and prospective marital satisfaction in a community sample of couples. The
primary predictor of marital outcomes for wives is partner hostile responsiveness, whereas for husbands it is partner withdrawal. Wife’s intimacy avoidance contributed unique variance to the prediction of husband’s marital distress; husband’s conflict avoidance provided a buffering effect for wives in the context of high husband hostile responsiveness. Results underscore the importance of differentiating hostile and distancing behaviors and, further, assessing withdrawal outside of the context of marital conflict.

Amato and DeBoer (2001) conducted a longitudinal study to understand the intergenerational transmission of marital instability, based on relationship skills and marital commitment. Parental divorce approximately doubled the odds that offspring would see their own marriages end in divorce. Offspring with martially distressed parents who remained continuously married did not have an elevated risk of divorce. Divorce is most likely to be transmitted across generations if parents reported a low, rather than a high, level of discord prior to marital dissolution. These results, combined with other findings from the study, suggest that offspring with divorced parents have an elevated risk of seeing their own marriages end in divorce because they hold a comparatively weak commitment to the norm of lifelong marriage.

Meyer, Vivian and O’Leary (1998) investigated husband’s sexual aggression in marriage through both spouse’s reports. Results indicated clinic wives reported significantly higher rates and frequencies of the husband’s sexual coercion factor and the husband’s threatened/forced sex factor than community wives. The relationship between husband’s physical and sexual violence is also examined. Husband’s sexual coercion is associated with their psychological aggression, whereas husband’s threatened/forced sex is related to moderate and severe physical aggression. Compared to non-abused wives
and moderately physically abused wives, severely physically abused wives reported the highest rates and frequencies of sexual coercion and threatened/forced sex.

Kurdek (1995) examined the link between husband's and wife's use of conflict resolution styles (conflict engagement, withdrawal, and compliance) and change in each spouse's marital satisfaction over a 2-year period. Spouse’s conflict resolution styles predicted change in only husband’s marital satisfaction, while spouse’s marital satisfaction did not predict change in conflict resolution styles for either spouse. Change in spouse’s conflict resolution styles - especially the frequency with which wives used conflict engagement and husbands used withdrawal - is linked to change in each spouse's marital satisfaction. Overall, husband's marital satisfaction is more frequently affected by how their wives resolved conflict than wife's marital satisfaction is affected by how their husbands resolved conflict.

Halford, Bouma, Kelly and Young (1999) reviewed of the association of individual emotional problems and marital distress with implications for therapy. Study revealed that emotional problems interact with marital distress in important ways. Although the causal connections between these emotional problems and marital distress are complex and only particularly understood, the available evidence shows that individual’s and couple’s problems often exacerbate each other. Consequently, regardless of whether the initial presentation is individual or couple focused, there is routinely a need to assess both individual and relationship functioning. Couples therapy, and in particular behavioral couples therapy (BCT), is an important element of effective treatment of emotional problems.
Allen, Rhoades, Stanley, Markman, Williams, Melton and Clements (2008) evaluated premarital precursors of infidelity. Couples in which the male engaged in marital infidelity are characterized, premaritally, by significantly lower male sexual satisfaction, lower male positive communication, and higher female invalidation, whereas couples in which the female went on to engage in infidelity are characterized, premaritally, by significantly lower levels of female positive communication, higher levels of male and female negative communication, and higher levels of male and female invalidation.

Amato and Rogers (1997) investigated the extent to which reports of marital problems in 1980 predicted divorce between 1980 and 1992, the extent to which these problems mediated the impact of demographic and life course variables on divorce, and gender differences in reports of particular marital problems and in the extent to which these reports predicted divorce. Wives reported more marital problems than husbands did, although this is due to husband’s tendency to report relatively few problems caused by their spouses. A variety of marital problems can end up in divorce. A parsimonious set of marital problems involving infidelity, spending money foolishly, drinking or drug use or both, jealousy, moodiness, and irritating habits mediated moderate proportions of the associations between demographic and life course variables and divorce.

Friedman (2004) found that high conflict reported to continue in some of the couples after divorce. He mooted the concept of the high-conflict post-divorce couple. It is suggested that the use of this concept encourages the belief that post-divorce conflict is more or less equally the responsibility of both parties, whereas such conflict is often driven by one parent. One of the main issue often leads to conflict is custody of the child.
Studies on marital therapy

This section is devoted to studies on marital therapy. Studies report the effectiveness of marital therapy in solving relationship problems of persons with sexual dysfunction. This section reviews studies on the efficacy of various marital therapies such as, behavioural marital therapy, structural-strategic family therapy, integrative behavioral couple therapy, traditional behavioral couple therapy etc.

Tilden, Gude, Hoffart and Sexton (2010) examined the relationship between depressive symptoms and dyadic adjustment, as well as between interpersonal problems and dyadic adjustment, during residential couple therapy and at a three-year follow-up. Mixed models are used in the analyses. Significant improvement occurred on all measures from admission to discharge and from admission to three year follow-up. During the observation period, improvement in depressive symptoms at the first time point predicted improvement in dyadic adjustment at the subsequent time point. Furthermore, the dyadic adjustment level at discharge predicted improvement in depressive symptoms in the follow-up period. There are only modest associations between personality variables and dyadic adjustment. The clinical implication is that couple therapy would lower the depressive symptoms among couples suffering from co-existing relational and symptomatic distress.

Tilden, Gude, Sexton, Finset and Hoffart (2010) studied the effectiveness of couple therapy during residential treatment and over a 3-year post-treatment period. Improvement in dyadic adjustment is evident after the therapy, and improvement is maintained at 3-year follow up. Dyadic adjustment change in the follow-up period is predicted by initial level on the Inventory of
Interpersonal Problems (IIP). Higher satisfaction on dyadic adjustment at discharge indicates better chances of couples remaining intact at 3-year follow-up.

Hill (2010) examined the concept of forgiveness in the context of couple and family therapy. Forgiveness is described as a complex psychological and relational process that is more a discovery via understanding and empathy than an act of will. Empathy is related to emotional intelligence, so empathy and forgiveness has developmental and relational benefits in relationships. He advocated that couple therapist can choose to give precedence to a model of forgiveness that sees it as a discovery of empathy and shared human connection within relationship systems which can create a setting for a personal and a systemic healing process.

Young, Negash and Long (2009) studied the efficacy of structural-strategic family therapy as a treatment modality for couples with problems of intimacy and sexual desire. Parents whose presenting problem involves a child with problematic behavior may also struggle with problems in their intimate relationship. Instead of speaking to these problems directly, however, the couple may communicate about their intimate problems via the metaphor of their “problem” child. Structural-strategic family therapy can then be utilized to strengthen the parental subsystem by establishing a parenting team, which in turn nourishes the partner subsystem. Success is then measured not only by improvements in the child’s behavior, but also by the enhancement of intimacy and sexual desire between partners.

Christensen, Yi, Atkins, Baucom and George (2006) carried out randomized clinical trial comparing traditional versus integrative behavioral couple therapy (TBCT vs. IBCT). Both treatments produced similar levels of
clinically significant improvement at 2 years post treatment (69% of IBCT couples and 60% of TBCT couples). Both treatments showed a “hockey-stick” pattern of change in which satisfaction dropped immediately after treatment termination but then increased for most of follow-up. The break point when couples reversed courses and gained in satisfaction occurred sooner for IBCT than TBCT couples, and those couples who stayed together generally fared better in IBCT than in TBCT. Finally, there is evidence of greater stability during follow-up in IBCT than in TBCT couples. There is little change in individual functioning over follow-up, but when change occurred it is strongly related to change in marital satisfaction. Given that this sample is selected for its significant and chronic distress, the data are encouraging about the long-term impact of behavioral couple therapy.

Christensen, Atkins, Berns, Wheeler, Baucom and Simpson (2004) carried out a randomized clinical trial compared the effects of traditional behavioral couple therapy (TBCT) and integrative behavioral couple therapy (IBCT) on seriously and chronically distressed married couples stratified into moderately and severely distressed groups. Couples in IBCT made steady improvements in satisfaction throughout the course of treatment, whereas TBCT couples improved more quickly than IBCT couples early in treatment but then, in contrast to the IBCT group, plateaued later in treatment. Both treatments produced similar levels of clinically significant improvement by the end of treatment. Measures of communication also showed improvement for both groups. Measures of individual functioning improved as marital satisfaction improved.

Doss, Thum, Sevier, Atkins and Christensen (2005) studied the mechanism of change in traditional vs. integrated behavioural couple therapy. The study revealed that measures of communication, behavior frequency and emotional
acceptance acted as mechanisms of change. Traditional behavioural couple therapy led to greater changes in frequency of targeted behavior early in therapy, whereas integrated behavioural couple therapy led to greater changes in acceptance of targeted behavior both early and late in therapy. In addition, change in behavioral frequency is strongly related to improvements in satisfaction early in therapy; however, in the 2nd half of therapy, emotional acceptance is more strongly related to changes in satisfaction.

Jacobson, Christensen, Prince, Cordova and Eldridge (2000) studied the efficacy of integrated behavioural couple therapy (IBCT). The results suggest that IBCT may be a promising alternative to traditional behavioural couple therapy (TBCT) and is a distinct treatment from TBCT. It was noticed that IBCT produced as much or more change in some areas of the relationship than TBCT, despite the emphasis on acceptance, rather than change, in IBCT. Consistent with the theory of change underlying IBCT the contextual shifts following successful acceptance work can be a more effective way of shifting the contingencies of reinforcement in a way that supports spontaneous change. Acceptance may not only be conducive to an improved relationship in its own right but may also at times be a more efficient way of producing behavior change than the direct attempts to induce it, which characterize TBCT.

Baucom, Atkins, Simpson and Christensen (2009) studied the prediction of long-term treatment response to couple therapies. Four groups of predictors (demographic, intrapersonal, communication, and other interpersonal) and two moderators (pretreatment severity and type of therapy) are explored as predictors of clinically significant change measured two years after treatment termination. Results demonstrated that power processes and expressed emotional arousal are the strongest predictors of 2-year response to
treatment. Moderation analyses showed that these variables predicted differential treatment response to traditional versus integrative behavioral couple therapy and that more variables predicted 2-year response for couples who are less distressed when beginning treatment.

Cordova, Jacobson and Christensen (1998) studied the efficacy of Integrative behavioural couple therapy (IBCT) over Traditional behavioural couple therapy in treating person’s with marital problems. Integrative behavioural couple therapy attempts to improve the Traditional behavioural couple therapy by incorporating emotional acceptance into behavioral change aspect of the Traditional behavioural couple therapy. The study revealed that IBCT couples expressed more non-blaming descriptions of problems and more soft emotions than TBCT couples during late stages of therapy. IBCT couples significantly increased their non-blaming descriptions of problems and significantly decreased their expressions of hard emotions and their problematic communication over time. Increases in non-blaming descriptions of problems are significantly correlated with increases in marital satisfaction. It also revealed that structural differences between the therapies affect initial levels of emotional expression in therapeutic session.

**Studies on emotional intelligence**

This section is devoted to the studies on emotional intelligence. Studies on the role of emotions in sexual functioning, relation between emotional intelligence and sexual dysfunction, cognitive and emotional variables influencing sexual functioning, and emotional regulation and sexual satisfaction are reported.

Stevenson, Stevenson, Rupp, Kim, Janssen and James. (2011) examined emotional component of sexual response. The sexual response includes an
emotional component, but it is not clear whether this component is specific to sex and whether it is best explained by dimensional or discrete emotion theories. To determine whether the emotional component of the sexual response is distinct from other emotions, participants rated 1450 sexual and non-sexual words according to dimensional theories of emotion (using scales of valence, arousal, and dominance) and according to theories of basic emotion (using scales of happiness, anger, sadness, fear, and disgust). In addition, ratings are provided for newly developed scales of sexual valence, arousal, and energy. A factor analysis produced four factors, together accounting for 91.5% of the variance in participant ratings. Using logistic regression analysis, they found that one word category or factor, labeled “sexual,” is predicted only by the new sexual arousal and energy scales. The remaining three factors, labeled “disgusting,” “happy,” and “basic aversive” are best predicted by basic (or discrete) emotion ratings. Dimensional ratings of valence, sexual valence, and arousal are not predictive of any of the four categories. These results suggest that the addition of sexually specific emotions to basic emotion theories is justified and needed to account fully for emotional responses to sexual stimuli.

Burri, Cherkas and Spector (2009) investigated whether normal variations in emotional intelligence—the ability to identify and manage emotions of one self and others—are associated with orgasmic frequency during intercourse and masturbation. Results revealed that emotional intelligence is not associated with the potential confounders of age and years of education, nor a significant association between emotional intelligence and potential risk factors for female orgasmic disorder such as age, body mass index, physical or sexual abuse, or menopause. We found emotional intelligence to be positively correlated with both frequency of orgasm during intercourse and
masturbation. Women in the lowest quartile of emotional intelligence had an approximate two fold increased risk of infrequent orgasm. The study concluded that low emotional intelligence seems to be a significant risk factor for low orgasmic frequency. Consideration of this behavioral risk factor may need to be incorporated into research into female orgasmic disorder and possible treatment approaches.

Carvalho and Nobre (2011) evaluated the main predictive factors of male sexual desire, considering medical, psychological and relationship factors. The study assessed following variables: psychological adjustment, dysfunctional sexual beliefs, automatic thoughts and emotions during sexual activity, dyadic adjustment, and the presence of medical conditions. Regarding cognitive and emotional factors, restrictive attitudes toward sexuality, lack of erotic thoughts during sexual activity, concerns about erection, emotions of sadness and shame in a sexual context are significant predictors of sexual desire. Dyadic adjustment and the presence of medical conditions are not significant predictors of male sexual desire. A multiple regression analysis including all these variables, in addition to age, indicated that lack of erotic thoughts during sexual activity is the only significant predictor of sexual desire. These findings suggest the importance of cognitive dimensions in sexual desire, particularly the role of attention focus and lack of erotic thoughts during sexual activity.

Nobre (2009) attempted to develop and test a cognitive-emotional model for sexual desire problems in women. Recent studies have shown the impact of sexual dysfunctional beliefs, negative cognitive schemas, negative automatic thoughts, and depressed affect on female sexual functioning. The conceptual model proposed that dysfunctional sexual beliefs work as predisposing factors, stipulating the conditional rules for the activation of negative
cognitive schemas. These schemas, once activated, would elicit negative automatic thoughts and emotions impairing the processing of erotic stimuli and interfering negatively with sexual desire. A path analysis is conducted to test the theoretical model proposed. Results supported the relevance of the model and its adjustment to the observed data, indicating the main role performed by cognitive and emotional factors on the predisposition and maintenance of sexual desire problems in women, and suggesting important implications for treatment.

Nobre and Pinto-Gouveia (2009) studied the association between cognitive schemas activated during sexual events and sexual functioning. Results showed that participants with sexual dysfunction activated significantly more negative schemas when exposed to sexually unsuccessful situations compared to sexually healthy individuals. Most men and women with sexual difficulties interpreted negative sexual events according to an incompetence self-schema (I’m powerless, I’m incompetent, I’m a failure). These findings are congruent with recent research indicating the tendency shown by individuals with sexual dysfunction to give attributions of an internal, stable and global nature to negative sexual experiences. Overall, results suggest specific faulty cognitive constructions underlying sexual dysfunctions and encourage the development of models and treatment approaches based on cognitive theory.

Nobre and Pinto-Gouveia (2008) examined the relationship between automatic thoughts and emotions presented during sexual activity and their correlation with sexual arousal. Results indicated several significant correlations among automatic thoughts, emotions, and sexual arousal. Erection concern thoughts in the men and failure/disengagement thoughts and lack of erotic thoughts in the women presented the most significant
negative correlations with sexual arousal. Additionally, sadness and disillusion are positively related to these negative cognitions and negatively associated with sexual arousal in both sexes. On the other hand, pleasure and satisfaction are negatively associated with the above mentioned negative cognitions and positively associated with subjective sexual arousal in both men and women. Overall, findings support the hypothesis that cognitive, emotional, and behavioral dimensions are closely linked and suggest a mode typical of sexual dysfunction composed of negative automatic thoughts, depressive affect, and low subjective sexual arousal.

Nobre and Pinto-Gouveia (2006a) investigated dysfunctional sexual beliefs as vulnerability factors to sexual dysfunction. Although effects have only reached statistical significance for the female group, both dysfunctional men and women endorsed more sexual dysfunctional beliefs than functional. Women presented significantly more age related beliefs (after menopause women loose their sexual desire; as women age the pleasure they get from sex decreases) and body image beliefs (women who are not physically attractive cannot be sexually satisfied). Additionally, sexually dysfunctional males presented higher scores (not statistically significant) on 'macho' belief (a real man has sexual intercourse very often) and the beliefs about women satisfaction (the quality of the erection is what most satisfies women). Overall findings support the idea that sexual beliefs may play as vulnerability factors for sexual dysfunction.

Nobre and Pinto-Gouveia (2006b) investigated the differences in emotional response to automatic thoughts presented during sexual activity between sexually functional and dysfunctional men and women. Results showed that both men and women with sexual dysfunction had significantly less positive emotional reactions to automatic thoughts during sexual activity. Sexually
dysfunctional men had significantly more emotions of sadness, disillusion, and fear, and less pleasure and satisfaction, compared to men without sexual problems. Women with sexual dysfunction had significantly less pleasure and satisfaction, and more sadness, disillusion, guilt, and anger. Findings are congruent with recent studies indicating that emotions related to depressed affect (sadness, disillusion, lack of pleasure) as opposed to negative emotions (mostly related to anxiety) are stronger correlates of sexual dysfunction.

Joshi and Thingujam (2009) examined the relationship between emotional intelligence and marital adjustment over and above personality dimensions and social desirability. The results reveal that emotionally intelligent couples tend to be well adjusted in their marital relationships. In particular, couples who score higher on perception of emotions, managing self emotions, managing others emotions and emotion utilization tend to be more adjusted in their marital life. It is believed that ability to perceive emotions can help one to understand verbal, nonverbal emotional cues of his or her partner. Managing self emotions and others emotions perhaps help partners to resolve conflicts and by utilizing emotions they can probably maintain well being of their spouses and themselves. In this way, being emotionally intelligent can possibly facilitate adjustment and satisfaction in marital relationship. This suggests that relation between emotional intelligence and marital adjustment is neither mediated by social desirability nor by personality.

Addis and Bernard (2002) studied to determine Ellis' irrational beliefs as well as emotional traits (anxiety, curiosity, anger) in couples attending marital counselling. The study supported Ellis' proposition concerning the importance of individual partner's emotional traits and accompanying irrational beliefs in marital adjustment and dissatisfaction. Self-downing and need for comfort are the dimensions of irrational thinking most strongly
related to marital dysfunction. Anger, anxiety distinguished individuals experiencing or not experiencing marital problems.

Kuffel and Heiman (2006) examined the effects of depressive mood symptoms and experimentally adopted sexual schemas on women’s sexual arousal and affect. Women with depressive mood symptoms reported significantly lower sexual desire than women with normal mood but no significant differences in arousal, orgasm, satisfaction, or pain. Women in both mood groups demonstrated significantly greater subjective sexual arousal, vaginal response, and positive affect in the positive schema condition than in the negative schema condition when controlling for anxiety. These findings support an information processing conceptualization of sexual arousal and suggest that an acute dose of cognitive sexual schemas can significantly impact subsequent sexual and affective responses.

Rellini, Vujanovic and Zvolensky (2010) tested the role of emotion dysregulation in regard to levels of sexual dissatisfaction and functioning among trauma-exposed cigarette smokers. When controlling for negative affectivity, type of trauma (sexual vs. nonsexual), daily smoking rate, posttraumatic stress symptoms, and anxiety sensitivity emotion dysregulation provided an independent and unique contribution to sexual dissatisfaction but not to sexual function. These preliminary findings suggested that emotion dysregulation is more important in understanding sexual dissatisfaction than previously recognized, and this topic is, therefore, worthy of further investigation.

An overview of studies
The review of studies indicates that sexual dysfunction is recognized as a major problem today. It affects people’s interpersonal functioning leading to
sexual and marital distress. Sexual dysfunction is highly prevalent throughout the world and its prevalence rate is reported to be 11 to 35%. A recent study indicates that 11% of men and 11% of women reported at least one sexual dysfunction in the last year, while another 68% of men and 69% (67–71%) of women reported infrequent or less severe sexual difficulties. The prevalence of sexual dysfunction increases as men and women age; about 40–45% of adult women and 20–30% of adult men have at least one manifest sexual dysfunction. Premature ejaculation is reported to be the highest problem among men followed by erectile difficulties, whereas in women lack of interest in sex and inability to reach orgasm is reported to be the common problem followed by lubrication difficulties. The prevalence of unreported sexual dysfunction and less severe sexual difficulties may be much higher than estimated sexual dysfunction. It is evident from the studies that even now people are reluctant to report their sexual problems or seek help for their sex problems from their physicians. This condition is still exists in the west even after sex revolution and modernization in their culture. Similarly Indian society is still embedded with myths, misconceptions and taboos regarding sex and sexual practices. This has prevented many men and women to report to their sexual problems to their physician and seek help for the same.

The common risk factors associated with sexual dysfunction reported by various studies are individual’s general health status, diabetes mellitus, cardiovascular disease, other genitourinary disease, psychiatric disorders, other chronic diseases, and socio-demographic conditions. Psychological factors reported to play a major role in the causation of sexual dysfunction are stress, interpersonal factors, anxiety and depression. The introduction of viagra and its inability to make permanent change in persons affected with
sexual dysfunction has substantiated the interpersonal factors in sexual functioning. Interpersonal aspects and cognitive elements in sexual functioning are gaining much importance today than in the past. But studies in these areas are almost nil in India.

There are some studies which examined the importance of sex therapy after is the impact of ‘‘viagra phenomenon.’’. Studies points out that viagra and other PD-5 inhibitors provide a method of improving erectile function, but it has become increasingly apparent that such pharmacological treatment on its own is often ineffective in the longer term. It reveals that in order to get its effects, it has to be taken on regular basis and needs to be integrated with psychotherapy which helps the couple to incorporate the pharmacological effect into their sexual relationship. At the same time many of the studies has questioned the effect of viagra and proposed the suggestibility factor of the drug. The long term inefficiency of viagra has underlined the need of sex therapies in the management of sexual dysfunction. Studies based on the effectiveness of sex therapy and combination of drug and sex therapy is almost nil in India.

Studies on sex knowledge points out that inadequate sex knowledge can make a person sexually dysfunctional. Poor knowledge of sex affects couple’s sexual functioning and in turn disturbs their interpersonal relationships. It is revealed that without adequate knowledge of human sexuality, men deem ‘sex’ as another agency of power, dominance and governance. Studies emphasize that imparting sex education in the young ages can solve many of these problems related to sexuality and sexual functioning. Necessity of imparting sex knowledge in young ages is evidenced by young people’s early initiation of sexual activity, involuntary context within which young people have sexual intercourse and high-risk
sexual behaviours prevailing among young people. So, an adequate level of knowledge can help young to protect their sexual health and it is one of the most promising means of improving young people’s sexual competence and levels of safer sexual practice.

Studies also points out the lack of sex education in Indian schools and colleges. As a result, ignorance and misconceptions perpetuate in Indian society, and sex is still considered as a taboo subject to talk. Parents in our society are reluctant to talk about sex education to their daughter as they found it embarrassing to discuss these topics. Generally, they avoid any mention of sex in their day-to-day relationships with their children. However, unlike previous research on the topic that identified parent-related factors (such as ignorance or embarrassment) as the main impediments to parent-young person communication about sex, one recent study has identified a reticence on the part of the young person to engage in such dialogue. Participants described various blocking techniques apparently used by the young people, including claims to have full prior knowledge on the issue, physically absenting themselves from the situation, becoming irritated or annoyed, or ridiculing parents’ educational efforts. The study also throws light into the fact that those who are expected to impart sex education in schools do not have sufficient knowledge to provide young people with adequate sexual health education.

Studies on marital adjustment highlight the importance of partner interaction and adjustment in sexual functioning. Several studies have suggested that marriage provides the best framework for a sexual relationship and satisfaction in sex is associated with the type of relationship in which they are engaged. As sex is an interaction between two persons, interpersonal factors plays a crucial role in the sexual functioning of the couples. Studies
reveal that interpersonal problems account for large number of sexual dysfunctions. Similarly most of the studies recognized the negative effects of sexual dysfunction on their partners and their relationship. Most of them expressed the view that sexual satisfaction had declined following the development of their partner’s sexual dysfunction. Studies on marital therapy suggest that improving the interpersonal relationship of the partners enhances the sexual functioning and satisfaction. Acceptance model based Integrated behavioural couple therapy has shown highly beneficial compared to the change model based Traditional behavioural couple therapy. But studies on the effectiveness of marital therapy in people with sexual dysfunction are almost nil in India.

Review of studies on emotional intelligence and sexual functioning reveals that emotionally intelligent couples tend to be well adjusted in their marital and sexual relationships. Couples who have the ability to perceive and manage self emotions and the emotions of others tend to be more adjusted in their marital life. It is found that ability to perceive emotions can help one to understand verbal, nonverbal emotional cues of his or her partner. Ability to manage self emotions and others emotions properly can help partners to resolve conflicts between them and by utilizing emotions they can probably maintain well being of their spouses and themselves. In this way, being emotionally intelligent can possibly facilitate adjustment and satisfaction in marital relationship. Studies reports that emotionally intelligent couples have the ability to manage their emotions during sexual activity, thus they have adequate sexual functioning and enhanced sexual satisfaction.

Review of studies points out that only limited researches has been carried out in the area of sexual dysfunction in India. Studies reported from India are limited to prevalence rate of sexual dysfunction, which is mainly based on
the hospital records. No studies have been carried on Indian populations which assess the relation between sexual dysfunction and variables such as sex knowledge, marital adjustment and emotional intelligence. Study to understand the role of sex knowledge in creating and perpetuating the sexual dysfunction has much relevance today in our population because Indian society is still coupled with myths and misconceptions regarding sex and sexual functioning. Either the parents nor the schools or colleges teach sex education in our society. Hence people have to depend up on unscientific methods to acquire sex knowledge. This nourishes culturally held beliefs and misconceptions leading to sexual dysfunction and dissatisfaction.

The traditional bound Indian society is well known for its long term marital relationships, but studies also reveals Indian women’s ability to live in sexual denial for years. So studies have to carry out to understand sexual functioning in Indian marriages, and the level of marital adjustment and sexual satisfaction among married couples. There are no studies performed to understand the role of emotions during sexual activity and the relation between emotional intelligence of couples in relation to their sexual functioning. Couples ability to perceive and manage emotions adequately can account for the success of marriage and sexual functioning. Therefore it is necessary to study emotional intelligence of the couples with reference to their marital adjustment and sexual functioning. This study is an attempt in that direction.

Studies which assess the effectiveness of psychological methods in the treatment of sexual dysfunctions are urgency of the hour. Application of cognitive methods in the treatment of sexual dysfunctions has yielded promising results. Cognitive therapy coupled with behavioural and systemic component is believed to be highly effective in the treatment of sexual
dysfunctions. But such studies are not being carried out in our population. So there is a need to evolve a sex therapeutic program which suitable to our culture. This study has developed a treatment model named ‘ERCoB model of sex therapy’ in treating patients with sexual dysfunctions and the effectiveness of this treatment model is to be tested in our culture. This study is carried out to understand the efficacy of this treatment model in treating person’s with sexual dysfunctions.

**Statement of the problem**

The problem under study is entitled as “Sexual Dysfunction in relation with sex knowledge, marital adjustment and emotional intelligence”.

**Objectives of the study**

1. To study the nature of sexual dysfunctions in Kerala.
2. To measure the effect of sex knowledge in sexual functioning.
3. To understand the relationship between marital adjustment and sexual adjustment
4. To study the role of emotional intelligence in sexual functioning
5. To measure the effectiveness of a sex therapeutic program (ERCoB) in the management of sexual dysfunctions.

**Independent variables of the study**

The study is intended to understand sexual dysfunction in relation to sex knowledge, marital adjustment and emotional intelligence. So variables such as sex knowledge, marital adjustment and emotional intelligence are taken as independent variables of the study.
Dependent variable of the study

Sexual dysfunction is treated as the dependent variable of the study.

Hypotheses of the study

The following hypotheses are formulated in this study.

1. Adequate sex knowledge results in better sexual functioning.
2. Better sex knowledge enhances foreplay (non-sensuality) between partners.
3. Better sex knowledge results in better sexual satisfaction.
4. Better marital adjustment results in better sexual functioning.
5. Better marital adjustment increases communication between partners on sexual matters.
6. Better marital adjustment increases frequency of sex between partners.
8. Better emotional intelligence would result in enhanced sexual functioning.
10. Sexual adjustment is a function of sex knowledge, marital adjustment and emotional intelligence.

Operational definition

1. Sexual dysfunction

Sexual dysfunction is defined as a disturbance in the sexual response cycle or as pain with sexual intercourse. Sexual dysfunction is operationally defined
for the study as follows: an inability of the male to achieve or maintain an erection to such an extent that he is unable to engage in satisfactory intercourse, an inability of the male to delay ejaculation sufficiently to enjoy lovemaking, inability of the female to attain orgasm, or an involuntary muscle constriction of the outer third of the vagina that interferes with penile insertion and intercourse.

(a) Male erectile disorder (Impotence)
Persistent or recurrent inability to attain, or to maintain an adequate erection, until completion of the sexual activity. In addition, those who score 5 or above in the Impotence subscale of the GRISS.

(b) Premature ejaculation
Persistent or recurrent ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes it. In addition, those who score 5 or above in the Premature ejaculation subscale of the GRISS.

(c) Female orgasmic disorder (Anorgasmia)
Persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase. In addition, those who score 5 or above in the Anorgasmia subscale of the GRISS.

(d) Vaginismus
Recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with sexual intercourse. In addition, those who score 5 or above in the Vaginismus subscale of the GRISS.