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EFFECTIVENESS OF CBT AND SEX THERAPY ON LOVE ATTITUDE AND SEXUAL FUNCTION AMONG PATIENT WITH PREMATURE EJACULATION

Mahi Khandelwal
Research Scholar, Department of Psychology, IIS (Deemed to be University), Jaipur, Rajasthan, India

Dr. Sudha Rathore
Senior Assistant Professor, Department of Psychology, IIS (deemed to be University). Jaipur, India

Abstract
There is a tremendous lot of emotional and relationship instability, as well as psychological pain, that may be caused by a lack of sexual functioning, which is vital since it is one of the most basic aspects of being human. According to Chevret et al. (2004)[1] and Rosen et al. (2004),[2] two other aspects that are impacted are an individual's feeling of well-being and their self-esteem. The stages of the sexual response cycle are used to categorise sexual dysfunctions. This classification technique was developed by psychologists. According to Masters and Johnson (1966),[3] dysfunctions are linked to the phases of the sexual response cycle, which include desire, excitement, plateau, orgasm, and resolution. These stages are related with inappropriate sexual behaviour. The Diagnostic and Statistical Manual (DSM-IV TR) has identified six distinct female sexual disorders: hypoactive sexual desire disorder, aversion disorder, sexual arousal disorder, female orgasmic disorder, vaginismus, and dyspareunia. The male sexual dysfunctions may be classified into many categories, including desire disorders (16%), excitement disorders (20%), orgasm disorders (35%), and resolution disorders (5-10%). These categories include conditions such as hypoactive sexual desire disorder and sexual aversion disease. The primary objective of our study is to investigate the impact of cognitive behavioural treatment (CBT) and sexual therapy (ST) on individuals' love attitudes and sexual dysfunction, specifically in the context of premature ejaculation.

Keywords- Sexual Desire, CBT, Premature Ejaculation, Love attitude, Disorder and Sex Therapy

Introduction
When a person or couple is unable to get pleasure from sexual relations, this is known as sexual dysfunction. Approximately 43% of women and 31% of men report experiencing sexual dysfunction to varying degrees. When a couple or person has trouble satisfying their sexual

[1] Chevret, M., Jaudinot, E., Sullivan, K. et al, (2004). Quality of sexual life and satisfaction in female partners of men with ED: psychometric validation of the Index of Sexual Life (ISL) questionnaire. Journal of Sex and Marital Therapy, 30, 141-55.
[2] Rosen R.C., Seidman S.N., Menza M.A., et al (2004). Quality of life, mood, and sexual function: a path analytic model of treatment effects in men with erectile dysfunction and depressive symptoms. International Journal of Impotence Research. 16, 334-340.
[3] Masters, W.H. & Johnson, V.E. (1966). Human sexual response, Boston: Little Brown

desires at any point in the sexual response cycle, this is also known as a dysfunctional sexual relationship (Hazimouratidis & Hatzichristou, 2007).[4]

Typical phases of a sexual response include arousal, plateau, orgasm, and resolution. Within the excitement phase of the sexual reaction, you'll experience both arousal and desire. Despite the prevalence of sexual dysfunction (43% of women and 31% of men report some trouble), many are reluctant to broach the subject. Talking to your spouse and doctor about your worries is vital since there are treatments available (Pereira et al., 2013).[5]

In most cases, four types of sexual dysfunction are recognised:

- Lack of sexual desire or interest is a symptom of desire disorders.
- The inability to feel bodily arousal or excitement during sexual engagement is known as an arousal disorder.
- Disorders related to orgasm, which include climax postponement or absence
- Conditions characterised by chronic discomfort, including sexual dysfunction

Although sexual dysfunction may strike at any age, it disproportionately affects those over the age of 40 due to the natural deterioration in health that comes with becoming older. Source: Kockott (2007).[6]

When people talk about sex therapy, they often mean the methods outlined by Masters and Johnson (1970),[7] particularly the "Sensate focus" component that is applicable to a wide range of sexual issues. Sex therapy often aims to educate and inform patients, change their attitudes, encourage them to take responsibility for themselves and their relationships, reduce performance anxiety, enhance communication skills and introduce them to new sexual techniques, help them alter their lifestyles and sex roles, and prescribe behavioural changes. Several elements are taken into consideration while making adjustments, including the partner's availability, the kind of dysfunction, socio-cultural influences, and the existence of other mental and physical health issues. An important factor is the therapist's openness and honesty in discussing the subject, as well as their capacity to manage their own sexuality (Manjula et al., 2003; Rosing et al., 2009).[8]

Cognitive Behaviour Sex Therapy

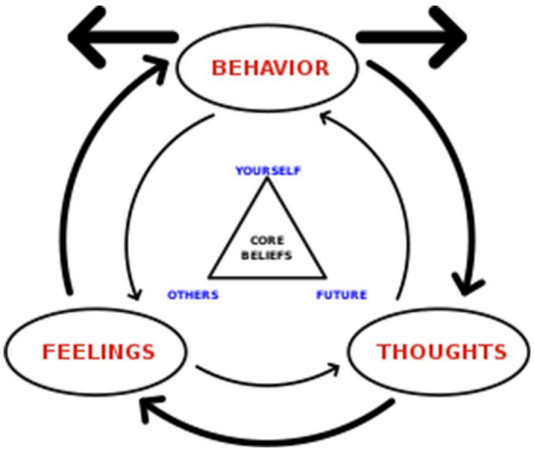
[4] Hazimouratidis & Hatzichristou, (2007). Sexual dysfunctions: classifications and definitions. Journal of Sexual Medicine, 4(1):241-250

[5] Pereira, V. M., Arias-Carrión, O., Machado, S., Nardi, A. E., & Silva, A. C. (2013). Sex therapy for female sexual dysfunction. International archives of medicine, 6(1), 37. doi:10.1186/1755-7682-6-37

[6] Kockott,G. Psychotherapy for sexual dysfunctions and desire disorders; 2007.

[7] Masters, W.H. & Johnson, V.E. (1970). Human sexual inadequacy, Boston: Little Brown

[8] Manjula, M., Prasadarao, P.S.D.V., Kumaraiah,V ., Mishra, H. & Raguram, R. (2003). Sexual dysfunction in single males: A perspective from India. Journal of Clinical Psychology, 59, 701-713



This picture is taken from Wikipedia[9]

At its core, the cognitive-behavioural model of sexual dysfunction seeks to explain the disorder by examining the intricate interplay between the four domains of human experience: ideas, actions, biology, and interpersonal functioning. Concerns about one's performance are a common source of the negative thoughts that have an adverse effect on sexual function; these thoughts can divert attention away from erotic cues, diminish sexual responsiveness and pleasure, and heighten negative emotions like anxiety, fear, and despair, which in turn can cause avoidance. An unreasonable expectation held by some women is that they should be able to achieve orgasm in every sexual encounter. Similarly, beliefs such as "women should not enjoy sex, and if she is, it reflects of a bad character," "a man should get erection at will and should maintain as long as the partner wishes" etc. may also lead to dysfunction in sexual performance.

Several parts of cognitive-behavioural sex therapy work together to help patients alter their dysfunctional sexual beliefs and practises. Both solo and couple therapy are available.

The unique requirements of each patient are carefully considered while developing a treatment plan, and targeted approaches are used to address various issues. Here are several interventions:

- Sexuality education programmes that dispel popular misconceptions
- Sexual communication training, scheduling and preparing for intimate moments, and enhancing one's sexual repertoire via heightened interest and novel sexual settings.
- Treatments based on desensitisation are used to lessen anxiety, enhance pleasure, and foster closeness via a series of targeted behavioural methods.
- Using cognitive restructuring techniques to combat sex-related stigma, misunderstanding, and negative thinking
- Changes in lifestyle, like getting more exercise and better sleep hygiene, which may affect sexual response.
- Talk therapy, both marital and individual, to work through issues like depression, anxiety, and personality traits that affect sexual functioning.

In the Sensate Focus behavioural programme developed by Masters and Johnson (1970),[10] couples engage in organised touching as a means of completing homework assignments.

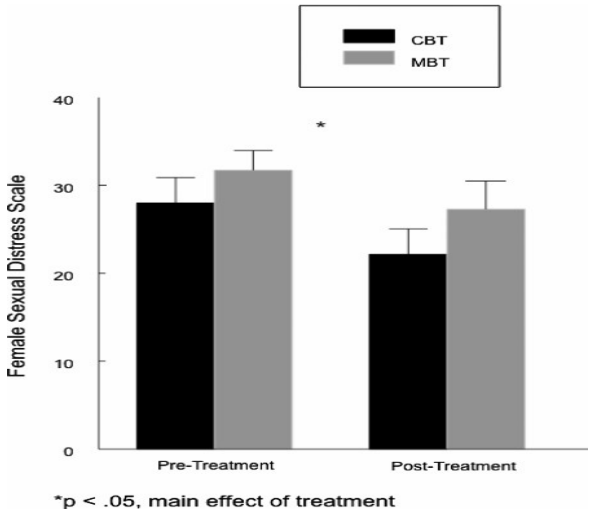
[9] Accessed from- https://en.wikipedia.org/wiki/Cognitive_behavioral_therapy [last visited on 1st of December 2023]
[10] Masters, W.H. & Johnson, V.E. (1970). Human sexual inadequacy, Boston: Little Brown

Sensate concentration exercises aim to help couples communicate better, overcome performance anxiety, identify each other's erogenous zones, and accept responsibility for one another. As a pair, you may practise increasing your awareness of your individual senses by taking turns in this sequence of activities.

As a couple, you should begin with what's known as "non genital sensate focus," which is getting to know one other's bodies, articulating your preferences, and discovering each other's pleasure spots. It is important to refrain from touching your breasts, pelvis, and genitalia during this time. The next stage is genital sensate focus, when the breast, pelvic, and genital regions are the targets of the pleasurable activities. Step three, vaginal confinement, entails inserting the device without making any thrusting motions. This provides a safe space for the guy to experiment with intravaginal sensations. Ending the process with vaginal confinement and pushing until ejaculation is the final phase. Partners may take their time and complete the steps at their own pace until they feel comfortable. The majority of sexual dysfunctions may be treated using this fundamental strategy, with the inclusion of problem-specific treatments. Just as the placements are recommended depending on the kind of difficulty, so are the approaches. In cases such as impotence and premature ejaculation, the female superior posture is advocated. Helen Kaplan's (1974)[11] New sex therapy is another option; it uses analytical and behavioural techniques to resolve interpersonal issues and dysfunction. PLISSIT model (Annon, 1976),[12] which incorporates patient-specific problem-and need-based therapy planning. The treatments may be offered at many levels, such as permission, limited information, precise directions, and intense therapy.

Effects of CBT and MBT on Sexual Distress

A between- (CBT, MBT) and within- (pretreatment, posttreatment) repeated measures analysis of variance examined the effects of treatment on sexual distress as measured by the FSDS total score. There was a significant main effect of treatment, $F(1, 11) = 5.07$, $p = .046$, but no treatment by group interaction, $F(1, 11) < 1$, indicating that women in both groups experienced a significant decrease in sexual distress (Figure 1). Overall there was a 6-point drop in FSDS scores from pre- (mean: 30) to posttreatment (mean: 24).



[11] Kaplan, H. S. (1974). The new sex therapy: Active treatment of sexual dysfunctions. New York: Brunner/Mazel.
[12] Annon J. (1976). Behavioral Treatment of Sexual Problems: Brief Threapy. Hagerstown, MD: Harper & Row

FIGURE 1.[13] Effects of cognitive behavioral therapy (CBT) and mindfulness-based therapy (MBT) on Female Sexual Distress Scale scores. Data represent mean plus standard error of the mean.

Fig. 2[14]

This clinical trial was conducted to evaluate the effect of sexual health education and CBT on the sexual assertiveness and satisfaction of newly married women from June to March 2021. Of 200 newly married women, 66 eligible women were randomly assigned to three groups ($n = 22$ in each group). None of the participants was excluded from the study and the data of all participants were analyzed (Fig. 2).

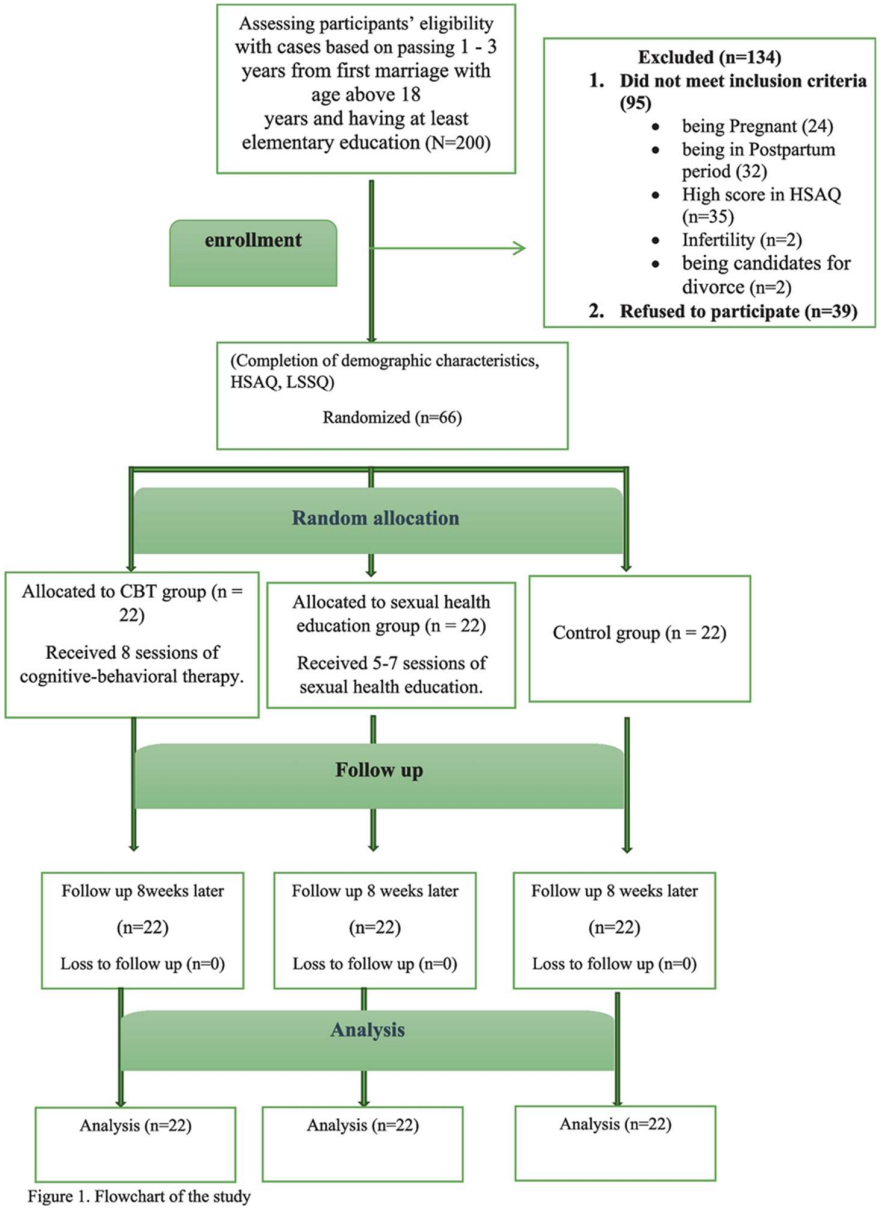


Figure 1. Flowchart of the study

[13] Retrieved from- https://www.researchgate.net/figure/Effects-of-cognitive-behavioral-therapy-CBT-and-mindfulness-based-therapy-MBT-on_fig1_221769827 [last visited on 1st of December 2023]
[14] Retrieved from- https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-023-04708-w/figures/1 [last visited on 1st of December 2023]

Table 1 The Comparison of sexual assertiveness before and after intervention between three groups[15]

Group	**Before intervention Mean (SD)**		**After intervention Mean (SD)**	
Cognitive behavioral therapy	48.77 (13.94)		69.37 (7.28)	
Sexual health education	48.90 (11.39)		66.94 (7.42)	
Control	45.04 (15.87)		42.74 (14.11)	
***P* value**	0.579[a]		< 0.001**	
Group comparison	**Mean Difference (95%Confidence interval)**	*P* value***	**Mean Difference (95%Confidence interval)**	*P* value**
CBT with control group	3.72 (-5.36 to 12.81)	0.358	26.62 (20.38 to 32.87)	< 0.001
Sexual health education with control group	3.86 (-4.57 to 12.27)	0.06	24.19 (17.93 to 30.44)	< 0.001
CBT with Sexual health education group	-0.13 (-7.88 to 7.61)	0.368	2.43 (-3.65 to 8.52)	0.699

1. [a]ANOVA
2. [**]ANCOVA
3. [***] Independent t-test

The mean (SD) score of the sexual assertiveness in the CBT group enhanced from 48.77 (13.94) before the intervention to 69.37 (7.28) after the intervention. The mean (SD) score of the sexual assertiveness in the sexual health education group increased from 48.9 (11.39) before the intervention to 66. 94 (7.42) after the intervention and changed from 45.04 (15.87) before the intervention to 42.74 (14.11) after the intervention in the control group. Before intervention, there was no significant difference among three groups, using ANOVA test ($P = 0.57$), and also in comparison with each other, using independent t-test. Eight weeks after the intervention, the mean score of sexual assertiveness in the CBT group was significantly more than that in the control group, using ANCOVA while controlling the baseline scores [AMD: 26.62, 95% CI: 20.38 to 32.87, $P < 0.001$]. Further, the mean score of the sexual assertiveness in the sexual health education group was significantly more than that in the control group [AMD: 24.19, 95% CI: 17.93 to 30.44, $P < 0.001$], However, there was no statistically significant difference between the two intervention groups [AMD: 2.43, 95% CI: -3.65 to 8.52, $P = 0.69$] (Table 3).

[15] Retrieved from- https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-023-04708-w/tables/3 [last visited on 1st of December 2023]

Pre-mature Ejaculation

The discomfort of premature ejaculation is real. The rapidity with which ejaculation occurs might make it impossible for a couple to have sexual relations. A couple may have infertility in certain instances. The ability to experience an orgasm is a source of complaint for women. Therefore, it is true that ejaculating too soon might be problematic (Serefoglu et al. 2011).[16]

Cognitive Behaviour Therapy for Premature Ejaculation (PE)

Of all male sexual dysfunctions, premature ejaculation affects one-third of males (20-30%) between the ages of 18 and 59. It could be the main or secondary one. Primary venous thromboembolism (PE) may have both psychological and organic causes. Among the former are penile hypersensitivity, decreased ejaculatory threshold, prostatitis, and urethritis. Diabetes and high blood pressure are two medical issues that might exacerbate PE. Between fourteen percent and fifty-eight percent of PE cases are attributable to mental health issues such depression, anxiety, and stress (Kennedy & Rizvi, 2009).[17]

The same reasons—embarrassment, humiliation, misunderstanding about therapy, unreliability of treatment options, and seeing it as a transient problem—are responsible for the fact that only half of individuals who are afflicted indicate that it disturbs them, and even less say that they seek aid. The majority of individuals are of the opinion that the disorder is entirely psychological, and that it manifests itself as a learned habit, a response to a big event or encounter, or a kind of sexual anxiety. They are upset because either the partner's feelings changed too rapidly or the sexual interaction ended in a negative way, and now they are angry. There is a possibility that the closeness and intimacy that are present in a relationship might suddenly go during a PE episode. An individual may emotionally withdraw from a relationship if they are experiencing negative feelings such as anger, humiliation, guilt, and frustration from their partner. The method in which the two people interact is altered, and it has an impact on their relationship. It is very uncommon for a woman to have feelings of being unwanted, exploited, and disregarded. When compared to the first year of marriage, consultation often takes place between five and twenty years following the wedding. The reason for this is because persons who have PE often wait a little bit longer. In the years after the birth of each kid and their first degree of autonomy, the situation becomes more precarious (Laumann et al., 2005; Metz et al., 1997).[18]

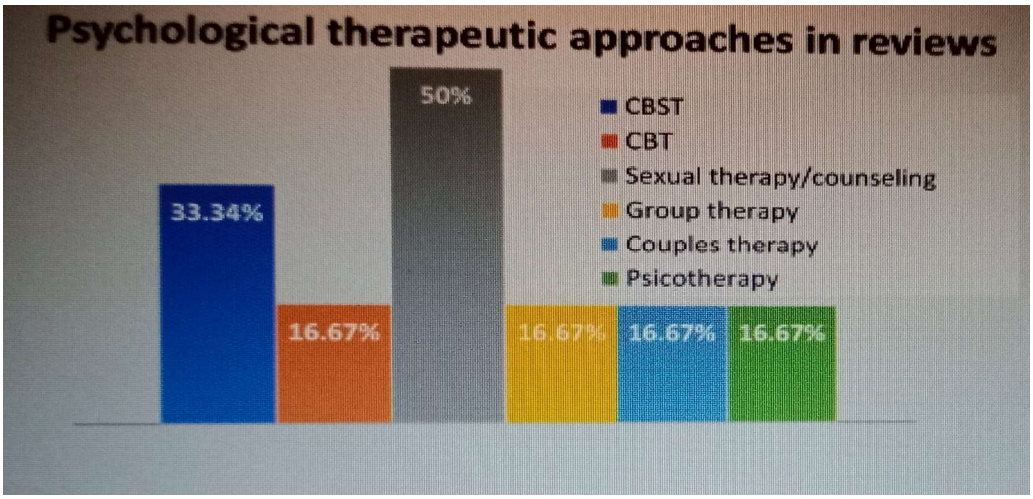
A reduced intravaginal ejaculatory latency time (IELT) and a patient's sexual history are the only criteria that should be considered for diagnosing PE, according to the American Urological Association (2004).[19] The three main criteria for a PE diagnosis are as follows:

(i) the patient or partner must report less control over ejaculation;
(ii) sexual intercourse must be less satisfying for the patient or partner; and
(iii) the patient or partner must experience distress due to the condition.

Interpersonal conflicts with partners, sexual guilt, unrealistic expectations of one's sexual performance, and negative cultural conditioning, such as early sexual encounters with

[16] Serefoglu et al. (2011). Prevalence of the complaint of ejaculating prematurely and the four premature ejaculation syndromes: results from the Turkish Society of Andrology Sexual Health Survey. J Sex Med 8(2):540-8.
[17] Kennedy SH, Rizvi S. (2009). Sexual dysfunction, depression, and the impact of antidepressants. J Clin Psychopharmacol, 29,157-64
[18] Laumann EO, Nicolosi A, Glasser DB, Paik A, Gingell C, Moreira E, et al. (2005). Sexual problems among women and men aged 40-80 y: prevalence and correlates identified in the Global Study of Sexual Attitudes and Behaviors. International Journal of Impotence Research, 17, 39-57
[19] American Urological Association Education and Research, Inc. (2004). Premature Ejaculation: Guideline on the pharmacological management of premature ejaculation

commercial sex workers who demand speed, can all play a role in conditioning one to have an orgasmic experience as soon as possible (Palmer & Stuckey, 2008).[20] Similar to how vehicles, parking, parks, etc., may train people to a certain pattern of sexual functioning, so can sexual abstinence, a new partner, unfamiliar circumstances, a very responsive and aggressive partner, and adolescent sex play. Once it develops in the aforementioned context, it causes performance anxiety in subsequent interactions, which in turn causes one to lose confidence, play the role of a spectator, and maybe develop secondary erectile dysfunction. Factors that keep it going include things like: mental health issues, marital strife and animosity towards one's spouse, the "don't touch" attitude towards one's privates, avoiding sexual encounters, and persistent prodding from a female partner. A person can lessen the amount of sensory input during the coitus process by engaging in distraction procedures such as thinking about non-sexual material, working on household finances, counting backwards, biting their lips, contracting their rectal sphincter, pinching themselves, pulling their hair, using alcohol, sedatives, or anaesthetic ointments; however, this strategy does not help with learning to tolerate the sensations and delaying ejaculation (Masters & Johnson, 1970; Porst et al., 2007).[21]



Regarding psychological therapies (Figure 3), where orientation was specified, the overview consisted only of behavioral (n= 1) and cognitive–behavioral sexual therapies (n= 2). To these were added, without specification of orientation, sexual therapies/counselling (n= 3) and group, couple, and psychotherapy therapies (n= 1 each).[22]

Sex Therapy

Sex therapy is a subset of psychotherapy that focuses on helping people overcome sexual dysfunctions in both sexes via the use of a variety of scientifically-proven techniques. The aforementioned viewpoints are now included into modern sex therapy (Althof, 1994).[23] Psychosexual treatment may include psychodynamic techniques as well as systems/couple and cognitive-behavioral approaches. A biopsychosocial approach to treatment is provided when these are integrated with medical therapy. Recovery of long-term, pleasurable sexual function is the end aim of therapy. Given the multitude of psychogenic variables that might contribute

[20] Palmer, N. & Stuckey, B.(2008). Premature ejaculation: a clinical update. Medical Journal of Australia, 188: 662-666

[22] Retrieved from- https://www.researchgate.net/publication/362316009_Psychological_Factors_Related_to_Impotence_as_a_Sexual_Dysfunction_in_Young_Men_A_Literature_Scan_for_Noteworthy_Research_Frameworks [last visited on 1st of December 2023]

[23] Althof S. What's new in sex therapy. Journal of Sexual Medicine-2010; 7(1): 5-13.

to sexual dysfunctions, it is crucial in modern clinical sexology to take into account the intricate interaction of these factors.

***The Precautions to be taken in Sex Therapy*[24]**

1. When engaging in sex therapy, it is important to consider cultural variables, such as whether or not to advise nakedness if neither partner finds it appropriate.
2. Avoid using colloquial language until absolutely necessary; doing so increases the likelihood that you will get your point across and reduces the likelihood that you or your patient will experience pain.
3. It is unnecessary to confront the patient with their deeply held gender biases if doing so will make them feel worse.
4. It is important to take things slowly throughout treatment when progress is being made.
5. It is necessary to address the relationship issue first when it is serious enough to cause sexual difficulties in the pair.
6. In order to make sure that sex therapy is feasible in regards to time, space, privacy, job stress, family interference, etc.
7. Obtain a detailed sexual history from each partner independently, making careful to ask about any elements that might be a risk, what could trigger an incident, and what could keep the problem going.

Table 2. Components of cognitive behavior sex therapy, on individual basis (based on cognitive model of erection by Nobre and Gouveia2000)[25]

Session	Components (individual therapy)
First week	Case formulation in the context of unique psychosexual history Psychosexual education (lectures by the therapist, instructional videos, books in local language) Exploration of sexual mythsPenetration is forbidden till the therapist advises otherwise
Second week	Reconstruction of sexual attitudes, socratic dialog
third week	Exploration of automatic thoughts and catastrophization (performance demand and failure anticipation), socraticdialog
Forth week	Relaxation exercises (mindful breathing) and mindfulness (nonjudgmental, present moment focus approach), to help the client control negative stress (the clients are encouraged to practice these exercises at home and record in log book till the end) Homework assignment: spending nonsexual pleasant time with partner (sharing past good

[24] Retrieved from- https://www.researchgate.net/publication/285054965_Cognitive_behavior_sex_therapy_unit-6 [last visited 28th of November 2023]

[25] Nobre P, Gouveia JP. Erectile dysfunction: an empiricalapproach based on Beck's cognitive theory. Sex. RelationshipTher 2000;15:351-366.Sex Med 2020;-:1e1212 Bilal and Abbasi

	times, saying good things to partner)
Fifth week	Learning sexual communication and love skills (spending time together, emotional expression, love talk, surprise gifts) Homework assignment: exploration of personal and partner's bodies (pay attention to emotions and thoughts in a nonsexual manner)
Sixth week	Review of relaxation exercises and mindfulness Homework assignment: sensate focus i; The client is instructed to play with his partner. He is instructed to involve his partner in mutual caressing to each other bodies except the genital area and breasts. He is further instructed to communicate his sexual thoughts and feelings. If the client and his partner reach a high level of sexual arousal, they may have an orgasm, but separately. The client is further instructed to communicate and discuss about this new sexual experience with his partner.
Seventh week	Review of love and sexual communication skills Homework assignment: sensate focus II; The client is instructed to give and receive stimulation of the whole body, including genital areas and breast, but not up to the orgasm, giving indications to each other. If the client and his partner reach a high level of sexual arousal, they may have an orgasm, but separately. The client is further instructed to communicate and discuss about this new sexual experience with his partner
Eighth week	Review of sensate focus i and ii Homework assignment: stop and start technique; The client asks his partner to stimulate his penis until it achieves an erection, then she stops stimulating until the penis becomes flaccid; repeat this exercise 3 times. Here, both partners can achieve orgasm but not through sexual intercourse. This exercise demonstrates that it is not necessary that a man constantly maintains the erection once reached (cognitive restructuring of a myth).

Ninth week	Homework Assignment: Stop and Start Technique with a lubricant; The client asks his partner to stimulate his penis with a lubricant until it achieves an erection, then she stops stimulating until the penis becomes flaccid; repeat the exercise 3 times. Here, both partners can achieve orgasm but separately. This exercise demonstrates that erection may decline, but that can be achieved again and creates a sensation of warmth and dampness (similar to vaginal walls inside). The client learns to enjoy sexual sensations together instead to go for sexual intercourse instantaneously.
Tenth week	Review of stop and start technique Homework assignment: undemanding sexual intercourse When the client learns to get erection, his partner inserts the erect penis into her vagina, slowly progressing to climax by making few ample movements. The client's partner detaches herself from him before ejaculation. The client eventually learns that penetration is not necessary for sexual satisfaction in every encounter, releasing the pressure to get an erection off the mind of client.
Eleventh week	Review of home assignments and discussion about hot issues Sexual penetration is permitted now onward.
Twelth week	Termination of therapy, review of therapy goals and outcomes Posttreatment assessment

Love Attitude

An individual's love attitude is something they're born with or developed over time; it's a product of their thoughts and feelings. They are intricate and developed as a result of life's events. An attitude is a person's inclination towards a certain value; it develops when they react positively to another person, place, thing, or event (the attitude object), and it shapes how they think about and interact with their partners. Love styles may and do evolve during the course of a lifetime. Even if you aren't in a relationship at the moment, you may still get a feel for your romantic tendencies by looking at these many types of love attitudes. A person's character and actions inside a relationship may be better described by adopting a loving attitude.

Love and its expressions have been the subject of much academic inquiry. Lee, a sociologist,

gained widespread fame in 1973 for his "colours of love" categorization of romantic preferences. Here are the six types of love relationships, according to Hendrick and Hendrick (1986):[26]

Marital Adjustment

A long-standing way to characterise the strength and longevity of a marriage is called marital adjustment. If both partners are happy and healthy in their marriage, it should last for many years. There is a correlation between marital satisfaction and health outcomes. Depression and unhealthy lifestyle choices are two ways in which a dysfunctional marriage may affect physiological functioning and health consequences. While adjusting to life as a married couple, partners should strive to unite around shared interests and values, keep lines of communication open (both emotionally and sexually), and support one another when they express themselves verbally and in writing. Divorce transition, "shortly after 'tying the knot' the new couple will enter into marital adjustment where they will establish their place within the relationship found their feet in the new life." There are a number of sexual dysfunctions that might develop if the adjustment creates changes in their lifestyle that impact their sexual closeness.

Since sexuality is fundamental to human relationships and adaptation, it seems to reason that partners of men who suffer from psychosexual dysfunction (such as erectile dysfunction, ejaculatory disruption, or both) would find it upsetting. When dealing with a partner's inability to conceive, many women wrongly believe that they have lost their attractiveness or that the male has found other women more appealing. Disruptions to communication, relationship breakdown, and the female partner's psychosocial functioning may result from poor self-evaluation and irritation with the male partner's performance issues. Sexual dysfunction is a common cause of marital dissolution or disruption, however many couples find ways to cope (Osborne, 1981).[27] Notwithstanding this gut feeling, there is a shocking lack of studies proving that spouses of psychosexually disturbed men really experience discomfort. **Notably, sexual dysfunction is reported in 9.2% to 13% of psychiatric outpatients and 30% of men visiting STD clinics in India** (Kar & Verma, 1978;[28] Kumar et al., 1983;[29] Catalan etal. 1981), making this shortfall all the more noteworthy.

When looking at the correlation between marital adjustment, psychosocial dysfunction, and distress, it was found that the more distress that patients' wives endured, the more impaired their psychosocial function and the worse their marital adjustment became. In addition, there was a correlation between increased psychosocial dysfunction and worse marital adjustment.

Analysis of the problem

When evaluating sexual dysfunctions, a number of different methodologies are often used. One of the most important ones is the detailed account of the case. In the majority of cases, the history is constructed from the individual histories of the pair as well as their combined histories. In order to determine the precise nature of the problem and how it has developed over time, it is required to conduct a comprehensive history. Details such as the frequency, severity, distress, duration, factors that contribute to the problem's progress or worsening, thoughts, coping mechanisms, beliefs, and therapeutic attempts are included in this consideration. In

[26] Hendrick, C. & Hendrick, S. (1986). A theory and method of love. Journal of Personality and Social Psychology, 50, 392-402.
[27] Osborne, D. (1981) Psychological aspects of male sexual dysfunction. Urologic Clinic of North America, 8 (1), 135-141.
[28] Kar, G.P. & Verma, LP. Sexual problems of married male patients. Indian Journal of Psychiatry, 20, 365-370. (1978)
[29] Kumar, S., Agarwal, A.K. & Trlvedi, J.K. Neurosis and sexual behaviour in males. Indian Journal of Psychiatry, 25, 190-197. (1983)

order to have a complete understanding of the history of each partner, it is necessary to have specifics on sexual development and attitudes on sexuality. Using this knowledge, it is possible that the underlying causes of the problem may be better recognised. In addition, it is of the utmost importance to know the partners' points of view on the matter, their objectives for the therapy, the degree of accountability they bring to the table, and the reasons why they are seeking treatment at this particular moment.

In order to determine whether or not sex therapy is suitable, the kind of sexual problem (primary or secondary, medical or psychological) must be considered. Providing therapy ought to be feasible in the event that the problem is secondary and originates from the mind. In the same way, therapy is more likely to be effective if both partners are devoted to getting well and are willing to work together, as well as if the relationship as a whole is healthy. This is true for both mental and physical health. To a large extent, sexual therapy is not recommended for women who are pregnant. There are a number of general themes that have to be discussed with each and every patient, despite the fact that it is essential to ask inquiries that are relevant to an individual situation.

It is strongly advised that you refrain from utilising colloquial phrases since they have the potential to be unsettling and unclear. In its place, make use of common vocabulary after having conversations with customers. In the process of taking a history, it is recommended to begin with questions that are somewhat unobtrusive before going on to inquiries that are more explicit. Initial inquiries should be open-ended, followed by questions that are closed-ended.

The specifics of the current issues, the quality of the relationship, the individual's family history, their early experiences, their current relationship with their partner, their present practises and preferences, and their fantasies that should be taken into consideration are some of the more general categories that should be taken into consideration. The history of a patient is just one piece of the picture; additional evaluations may examine the patient's degree of depression and anxiety, as well as their sexual knowledge, dysfunctions, and attitudes towards sexual practises.

Formulation of the Case for Therapy

When all of the pertinent sources of information, including as the patient's history, assessments, physical examinations, and medical records, have been acquired, the case is then ready to be treated. Through the use of the phrase, the issues have been better comprehended, and the logic for the treatment method has been strengthened. There are three basic categories of information that serve as the foundation for the formulation. These categories are the predisposing, precipitating, and sustaining. There is a predisposing element for both the client and the wife in this scenario, and that is a restrictive upbringing, in which sexual matters are not addressed openly. If a woman is told that having sexual intercourse is a terrible experience, for instance, she can develop a fear of the process of having sexual relations. Another widespread misunderstanding is that the guy is completely responsible for having effective sexual relations and that he should be able to enter in any given circumstance. This is a typical mistake. According to the husband's point of view, he ought to be the one going through with the sexual act. In addition to his inability to engage in sexual activity that is productive, he also struggles with emotions of inadequacy, guilt, and worry around his performance. It is most probable that the husband's premature ejaculation was caused by his wife's refusal to cooperate, her ranting and screaming, and her guilt of herself for not being able to enter the room. It is quite

probable that these factors caused him to feel uncomfortable, made him feel inadequate, and caused him to take on the role of a spectator. The unreasonable expectations that his wife has placed on him have had a negative impact on his performance, which has further exacerbated his unease.

There are a number of factors that contribute to the persistence of performance anxiety. This anxiety is characterised by a fear of failure, as well as a desire to avoid or act as a spectator during sexual encounters. Because of a lack of knowledge about sexual functioning, shame over previous failures, and myths about the body's ability to carry out sexual functions, negative automatic thoughts such as "will I be able to penetrate successfully?", "what if I fail?", and "my wife would think that I am sexually inadequate" come up during sexual activity. These thoughts are triggered by the fact that you are engaging in sexual activity. A number of factors contribute to the dysfunction, including the wife's unreasonable expectations, her anxieties about infertility, and her dread of pain. "What if it hurts and there is damage to the vagina?", "I cannot tolerate the pain," and "my vagina cannot accommodate the size of the penis" are some of the ideas that are associated with the sensation of discomfort. The dysfunctional cycle of infertility is maintained by these mental and behavioural factors again and over again.

Conclusion

Despite the fact that sexual dysfunctions are the most prevalent health concern that can be seen in both men and women, the amount of attention that seems to be paid to this field appears to be quite limited. A great deal of secrecy and a lack of understanding exist in this field, which contributes to an increased number of difficulties. In the process of predisposing a person to acquire issues, as well as in the process of contributing to and perpetuating dysfunctions, psychological variables play a significant role. When it comes to the therapy of secondary sexual dysfunctions, psychological treatments are an essential component within the therapeutic process.

Sex treatments that are primarily focused on cognitive and behavioural concepts have been demonstrated to be successful in the treatment of dysfunctions that are experienced by both males and females. The most important aspects of these treatments are the enhancement of knowledge, the promotion of reciprocal responsibility, the facilitation of attitude change, the elimination of performance anxiety, the enhancement of communication and sexual skills, the modification of life styles and sexual roles, and the prescription of behavioural changes. Moreover, there are certain approaches that may be used in order to handle various types of dysfunction. It seems that the psychological therapies are also helpful in maintaining the gains made during therapy and in improving the quality of life that the couple experiences in their marriage.

In addition to the characteristics of the investigation, the emphasis of the study is on the efficacy of cognitive behavioural therapy (CBT), specific therapy (ST), combined CBT and ST in the treatment of patients with PE. The development of premature ejaculation in males is caused by a number of different psychological factors. A combination of psychosexual and medical therapy is required in order to lessen the severity of PE.

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