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ETIOLOGICAL FACTORS OF PSYCHOLOGICAL NATURE IN SEXUAL DYSFUNCTIONS

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Abstract

Through this paper, we aimed to better understand the psychological factors that influence the development and evolution of sexuality. This work that can be beneficial in the evaluation stage of clients who come to the office with sexual dysfunctions of a psychogenic nature and in that of conceptualization of the case as well as in following essential steps in establishing the therapeutic objectives and strategy and, of course, in the evolution of the case.

At the same time, we wanted to draw attention to the multitude, variety, complexity and interactions between personal, social, biological, relationship factors, etc. which influences and enhances the appearance, maintenance and, why not, amelioration of sexual dysfunctions, each of which can be a significant node in the therapeutic approach to sexual dysfunctions.

We also aimed to review, from a cognitive perspective, the psychogenesis factors of sexual dysfunction, cognitive structures, the transformation of an irrational / dysfunctional thinking style into a rational, adaptive, healthy one, (but not the only one) among the aspects that contribute to the success of any therapy.

Key words: sexuality, cognitive schemas, irrational cognitions, cognitive therapy, etiological factors, automatic thoughts.

INTRODUCTION

Psychological development begins before birth and continues throughout our lives, through the interaction of biological, psychological, social factors that act on the person and have a modeling, regulatory, adaptive role.

Sexuality also develops throughout life, in the form of pleasure, sexual abilities, interpersonal sex-role abilities, as well as in the form of sexual orientation, sexual identity and the assumption or not of the role. Under the pressure of education and society, as well as one's own experiences or one's own judgments, assessments and inferences, the axiological framework that will circumscribe sexual conduct develops, from sexual responses, genetically and physiologically mediated, to the motivation of sexual behavior and preferences.

Sexual difficulties / disorders (of the individual and/ or the couple) occur at the intersection between psychological factors and one or more of the biological, social, environmental, educational factors. The general vulnerability of the person to sexual problems can be interpreted in terms of risk factors versus individual protection factors, in the context of the

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person's general ability to effectively face and manage significant adversity and to keep the experience to use and future events (personal resilience). A person is all the more vulnerable to developing a number of sexual difficulties (and not only), the higher the number of risk factors, the longer the period of exposure to them, and the lower the degree of personal resilience. There is also the situation in which a person with effective resilience mechanisms can develop health problems, for a longer or shorter period of time, even in the conditions of a single event, if it is of very high intensity and the stressors are much stronger than individual protection factors.

THEORETICAL APPROACHES

1. Considerations on the development of human sexuality

The process of organizing sexuality is not well understood or easy to explain, and the information is most often explanatory, ascertaining, and not proactive; as a result, in conditions of similar bio-physiological organizations, sexuality (from the first signs of arousal and sexual desire, to the actual sexual behaviors and the degree of satisfaction felt) develops differently, has different ways of expression, deeply individual, precisely because of the multitude of variables, influences and interferences.

Studies show that there are forms of pleasure from the intrauterine period, a few months before birth, which is easier to observe in male fetuses, by the appearance of erections, both spontaneously and when sucking fingers or swallowing various injected substances in amniotic fluid. In girls, experiments were performed after birth, finding that lubrication of the vagina and swelling of the clitoris occur, even at the age of one day.

Child sexuality, in the sense of pleasure in the senses, not sexuality strictly related to the sexual organs, is quasi-present. Babies raise and touch their feet, toes, clap, shout loudly in different ways and wait for the reactions of those around them; they like to be held in their arms, massaged, caressed, tickled. They explore their body, including touching their genitals. Over time, boys earlier, in the first 6-7 months, and girls at about 10 months, begin to touch their genitals in particular. It is very likely that when the touches move to the stage of sensuality, babies begin to associate the touches with emotions and ideas of pleasure (they will resort throughout life to touch, from time to time, the genitals, just to rediscover the pleasure and / or the peace they discovered in the first year of life). Up to the age of 3, children will masturbate from time to time, especially if they have not received reactions of disapproval from adults. They can use their fingers, palms or rhythmically rub against various objects.

Around the age of three, children tend to hide or stop the actions of self-achievement, self-stimulation, most likely due to the reactions of adults, who are more likely to occur during this period.

Early childhood is a stage in which sexual differentiation continues and behaviors related to obtaining pleasure are diversified. Physical contact with others, especially caregivers, self-exploration, peer observation, game orientation during individual exploration or after adult guidance, will all influence in one way or another, the child's sexual development, choices and role-sex behaviors, expectations and beliefs about sex. Moreover, the reactions of others to the child's reflexes and sexual behaviors, as well as to the behaviors and interests of exploration, in general, the information that adults provide children about sexuality, interpersonal relationships, conduct towards the opposite sex and, especially, the model he offers in the interaction with his partner are opportunities for early sex education, especially since early childhood is the stage when boys imitate their fathers and have a romantic attachment to mothers.

A balanced behavior of caregivers, with natural reactions, adapted and appropriate to the child's age, with explanations provided appropriately, depending on the age, the child's ability to understand and, especially, how much and what he wants to know, increases the chance for a balanced development of the personality as a whole, with the understanding and acceptance of one's sexuality.

In preschool, boys and girls play together, there is not necessarily a differentiated preference for boys' games and girls' games, even in the presence of a clear sexual identity. Girls play with cars, with guns, just as boys can imitate household activities - washing and ironing clothes, cooking, knitting, in general what they see in caregivers. However, there is an apprehension of boys for a more dynamic style, even with notes of aggression and risk-taking, while girls prefer games and static interactions, which cause an exchange of emotions and empathic expression. As sexual behaviors, self-exploration, touching, interest in sexual games are maintained, but new behaviors also appear: sexual games with other children, voyeurism, interest in nudity, exhibitionism, as a sexual language appears.

Again, inability, inhibitory interventions in adults can interfere with the natural development specific to this stage. Manifestly expressed concerns of the father when the 4-5 year old boy wants a „girl's" toy raises in the child's mind a series of questions and ambiguities: „There is something wrong with me, with my masculinity or the father's"; if comments like „No, what, are you a girl?" one's own sense of masculinity is questioned.

In essence, we are not 100% male or female, and the „percentage" of the opposite sex in each of us is more beneficial than suggesting potential problems: a little feminine in a boy can mean an easier understanding of the opposite sex, greater capacity for empathic communication with the opposite sex, etc. which leads to better communication, less conflict and, for a couple, a better quality of life. Also, the feminine peak in a boy is more related to the paternal instinct than to homosexuality. Much more harmful for the formation of sexual identity can be moments of confusion generated by violent reactions to choices, preferences at one time or another or, later, the inability of the parent to explain, to accompany the pubescent and adolescent in the process of change, to agree with the child's choices and preferences. I think it would be much more disastrous for a parent for his child to be unhappy all his life (with himself, with others, with life in general) than to have a child whose sexual life does not correspond to the generally accepted „norms", but through which he does not harm himself or others, for which he has a partner with whom he can evolve and live in harmony, in a couple and in society.

The age of 7-8 is also the period in which children begin to seek and assert their independence, and interest in sex and sexuality remains in the background (continues to masturbate occasionally, but only to reduce anxiety, after as interest in the genitals seems to be compared to others rather than for pleasure). Legendary heroes, fictional characters, with special powers and qualities, but also with the unwritten laws of interaction and reporting to the social environment, are more and more present in the child's life. In the interaction with adults, from the romantic love he had for the parent of the opposite sex, the child behaves coldly and no longer accepts manifestations of this love with other children. From a sexual point of view, they construct their sexual identity mainly by identifying with the parent of the same sex, but also by testing behaviors observed in others or in fictional characters; boys continue to detach themselves more and more from their mother's influence; insufficient or absent detachment, the mother's perseverance in carrying out translated behaviors, most often, through hyperprotection, often interferes negatively with the process of sexual maturation. At the same time, the idea of the implications of the absence (non-existence or blurred play of the sex role) of the same-sex parent in the child's life, on sexuality and the development of role-sex behavior can be speculated, as well as, in general, in the process of emotional maturation and gaining autonomy. The processes of identification and counter-identification with attachment / caregivers, social regulation both within the family of origin and in the interpersonal environment, through the feedback provided by congeners, are significant factors in human sexual development, in the foreshadowing of sexual preferences, shaping sexual motivation, even understanding and accepting sexuality.

At puberty, under the pressure generated by hormones, boys begin to perceive girls' interest in them and, although shy, they also begin to show interest in girls (they are more attentive to dress, to cleanliness). It seems that, in a first phase, the pubescents return to the feelings of love towards the parent of the opposite sex, this time with sexual notes, not only with the romance specific to childhood. However, moral courts intervene (the child is in the conventional stage of moral development, in which social conventions on good and evil are accepted) and, to avoid feelings of shame, embarrassment, guilt, the preadolescent prefers to hide his increasingly loaded desires, sexuality, in even aggressive behaviors, of opposition and revolt towards the parent of the opposite sex, with quarrels, disregard, blame, etc. The beginning of sexual interests for VIPs, actors, some teachers, etc. it could be the result of shifting sexual attention from the parent of the opposite sex. Slowly, shyly, in a longer or shorter period, they begin to express their feelings towards colleagues, at first in a romantic manner, then in an increasingly impetuous sexual manner. The interest in sex is more and more intense, and teenagers are starting to have more or less skillful courtship behaviors.

Conformism towards one's own gender or, on the contrary, ambivalence or nonconformism can be a first indicator for homo- or heterosexual orientation, but neither sufficient nor necessary. The content of sexual fantasies that appear in preadolescence, the convergence between one's own sex and behavioral drivers could have a greater consistency in anticipating sexual orientation and preferences.

Preadolescence and adolescence are extremely sensitive and important periods in sexual development, the person now combines the concern for the transformations that his own body goes through, with the concern for the opposite sex or, in general, for sex. The feeling of being psychologically compatible with one's own, the expectations of others and the pressure to conform to sex stereotypes, the feeling of superiority over the opposite sex are all factors that interfere with the evolution and assumption of sexuality.

There is interest in belonging to a social group, its acceptance or rejection can influence, in the context of emotional vulnerabilities, the evolution of the person's personality, in terms of self-esteem, image and self-confidence, otherwise extremely unstable at this age, with major reverberations in the natural development of sexuality. The group provides the framework for each to explore compatibility with their own gender, as well as the feeling of superiority of their own gender over the other.

Often, the group is the one that opens the perspective of sexual interactions, in the sense of facilitating the interpersonal behaviors of seduction, courtship, in general of expressing sexuality. Group processes (establishing hierarchies, dynamics of preferences and rejections, regulatory feedback, information flow, etc.) leave their mark, directly or indirectly, on the person's evolution, opening or closing doors to understanding, assuming, developing sexuality.

Also, in adolescence, boys and girls are very receptive to cultural messages about „what a man / woman should look like" and experience all sorts of behaviors associated with the socially promoted image (boys begin to be concerned with appearance, she had a perfect body, and girls adopted, for example, outfits that highlighted their sexuality, often out of the ordinary and even less to the liking of their parents).

The first sexual experience is often considered to have an impact on sexual adaptation and subsequent sexual development. However, studies have failed to demonstrate the universality of this, the significance given to the first sexual experience being, rather, the specificity of the person's cognitive-emotional structure, the person's beliefs, attitudes and values, the attitude of those around him, the reaction of the reference group, as well as the possible consequences or consequences.

The challenges of the young adult pass in the sphere of consolidating the financial independence, of assuming the responsibilities of couple and family, of the social and professional evolution, all these being circumscribed to the socially accepted and promoted patterns.

Intrapsychic conflicts of a sexual nature, with or without impact, of longer or shorter duration, situational or generalized, can occur at any time, at the interaction between the bio-psycho-social reality of each of us, as it is structured in terms of beliefs, desires, personal needs, individual mental maps through which we filter the immediate experience, etc. and sex-role expectations, the patterns that society imposes in more or less subtle ways.

Social scripts carry „norms" of conduct, including sexual. They prescribe what, how, when you have to feel, think, carry out a certain behavior, in order to be in the norm that prescribes a certain situation (what "should" you wear to the wedding, how "should" be the mother-in-law relationship etc.).

If the person's biological and personality do not contradict these scenarios, things can go smoothly, and subsequent sexual evolution is self-sustaining, especially as social scenarios contribute, through decreasing insecurity, to decreased anxiety and, consequently, gaining a sense of confidence and self-confidence, with increasing satisfaction.

However, if there is a conflict between what is required and what the person wants / can / consider, the evolution in terms of sexuality can register slowdowns, derailments and even blockages.

If the person is sexually assumed, has a set of healthy cognitive beliefs about himself, etc., he can „resist" even in the conditions in which he intends to live his life differently from how prescribed by social patterns, selectively, with a sporadic or total spacing.

However, if his needs and desires are grafted on a series of cognitive and emotional vulnerabilities, the impact of the deviation from the rule can result in as varied effects as possible, from simple recurrent depressive states, to the development of clinical symptoms and / or structuring a personality disorder or even mental illness.

Consequently, although there are numerous thorough studies, according to all scientific rules, the process of sexuality development is a great unknown.

2. Risk factors in the occurrence and maintenance of sexual dysfunction

Sexual dysfunctions are generated and maintained by a multitude of factors, with various origins and strictly customized manifestations.

In general, the specialized literature classifies etiological factors according to two criteria:

- by their nature, they are exogenous factors (physical, chemical, biological and psychosocial agents) and endogenous factors (genetic factors, responsible for causing genetic abnormalities);
- according to the function they fulfill in the genesis / appearance of the disease, there are triggering factors, predisposing factors, precipitating factors, maintenance factors and contextual factors, specifying that their division has, rather, a didactic role.

Predisposing factors refer both to early life experiences as well to aspects related to the physical constitution of the person. These factors are often insufficient to generate sexual dysfunction, but they subsist and contribute to the general vulnerability of the person:

- *constitutional predisposing factors* - inherited anatomical and / or physiological features, hormonal disorders, delayed puberty, temperamental characteristics, degree of physical endurance, personality traits;
- *predisposing factors related to development* (developmental factors) - type of primary attachment, parental style / pattern, exposure to violence (psychological, sexual, physical), traumatic events, early sexual experiences, sexual abuse, messages, expectations, religious constraints / (including poor sex education, inadequate information about sex and sexuality).

We can add to the list of predisposing factors the central and intermediate cognitive structures, coded in the form of maladaptive cognitive schemas, and the evaluative cognitive structures - general and intermediate irrational cognitions, which we will treat separately in the next chapter (David D., 2015).

The precipitating factors reside in any life experience, to which the person attributes, con-

sciously or not, an intensely negative meaning. They are what we call intensely stressors, and the reaction (sexual dysfunction) is the body's response to stress. The main characteristic of precipitating factors is that they have a strictly personal character, being difficult, if not impossible to anticipate what are the factors / moment / conditions / circumstances that guarantee the appearance / absence of sexual dysfunctions, namely from the concrete existence or psyche of the person whether or not it is a trigger for sexual problems. Moreover, what for one person is a trigger for sexual dysfunction, for another person can be a motivating / determining and triggering factor of feelings, behaviors and attitudes generating sexual satisfaction and fulfillment, due to its extremely particular character which filters and transforms the trigger event.

In essence, we can consider that the pathological condition can occur in the context in which the person's goals, desires, expectations, hopes, expectancies contradict (cognitive discrepancy) with various events that the person goes through, considered activating events, and "the greater the cognitive discrepancy is, the more severe the psychological problems are" (David D., 2012).

The ascertaining studies managed to group some factors under the title of precipitating factors of sexual dysfunctions, in the sense that they have a higher probability of producing sexual dysfunctions, but not obligatory; they can also cause sexual dysfunction of different durations or even permanent:

- events generally considered to be extremely stressful: loss of any kind (death, divorce / separation, loss of job, even change of place of residence), infidelity of the partner, birth, menopause / andropause;
- infertility, postpartum experiences;
- humiliating sexual experiences, even a first unsuccessful or humiliating sexual experience;
- emotional disorders, depression, anxiety;
- intramarital conflicts;
- substance abuse.

The maintenance factors are those that turn a negative sexual event, singular or episodic, into a lasting sexual dysfunction, with great chances of chronicity. We consider that the impact of maintenance factors is the most difficult to manage in therapy, especially since other people, relationships, environments in which the client lives are involved. For example, any problem of the client's partner can become a factor in maintaining sexual dysfunction and, moreover, the difficulties of each can become a trigger for the other.

- anxiety, depression, self-confidence / image / self-esteem; loss of self-confidence from a sexual point of view, performance anxiety;
- aspects related to the partner: a sexual dysfunction of the partner, affective-emotional peculiarities, disorders on axes 1 and 2;
- intrapsychic conflicts;
- prolonged interpersonal conflicts, within the family or at work;
- sustained stress, personal, occupational, emotional;
- acute or chronic health problems;
- problems associated with aging etc.

Contextual or favoring factors are those stressors that interfere with the individual's or the couple's life, which act temporarily, but through the "echo" or psychological reactions, relationships, etc. may become chronic, with longer-lasting impairment of sexual function:

- financial difficulties, unemployment;
- fatigue (raising a child, busy periods at work, caring for a sick person, etc.);
- lack of a space to ensure privacy;
- different schedules of the two partners;
- failure to get pregnant or any other health problem of one of the two partners etc.

A special set of factors with a significant role in the occurrence and maintenance of sexual dysfunctions we consider to be local cognitive structures, in the form of irrational automatic thoughts, which we will discuss further (David D., 2015).

3. Cognitive structures and their role in the occurrence and maintening of sexual dysfunctions

The central cognitive structures (cognitive schemas) are factors of general vulnerability. Cognitive schemas are emotional patterns,

referring to oneself, others and/ or life, in general, in which emotions, physical sensations, cognitions, memories are encrypted; they appear and develop in childhood and/ or adolescence, feed throughout life and are dysfunctional, to varying degrees. They remain as matrices with which we signify current experiences or as "abstract cognitive maps that guide us in interpreting information and solving problems" (Young &, 2015). Unfortunately, maladaptive schemes mediate inefficient, wrong solutions and generate self-sabotaging behaviors through the coping mechanisms it uses.

Some authors consider that there are two central cognitive schemes (Beck A.T., 1995, 2012 - the selfless / helpless scheme, in which the central belief is that he/she is a bad, worthless and helpless person, and the self-exclusion / non-acceptance scheme - unlovable, in which the person thinks he/she is not accepted and not appreciated by others). Other authors consider that there are 18 such cognitive patterns, grouped in four domains / categories representative of unmet emotional needs (Young &, 2015), as follows:

Area I - Separation and Rejection includes Abandonment / Instability, Distrust / Abuse, Emotional Deprivation, and Deficiency / Shame

People with cognitive patterns in this field have great difficulty in developing secure and satisfying attachments to other people because of the belief that their needs for stability, care, security, love, and belonging will never be met. In most cases, the family of origin was cold, critical, abusive, unstable, socially isolated, creating the context of a traumatic childhood for the client. In adulthood, the client will either try in vain to build a surrogate family environment and throw himself into various and destructive relationships, or isolate himself from the rest of the world to avoid the emotional pain of childhood.

They will live with the conviction that they cannot establish, obtain and maintain a satisfactory emotional connection with anyone, and they will not receive affection, attention, understanding, support, etc., no matter how hard they try (emotional deprivation).

They will live with the quasi-permanent fear that they will be abandoned by the significant people in their lives for someone better, that they are an unsatisfactory and unpredictable presence for the other (Abandonment / Instability scheme). Some people believe that if given the opportunity, others will abuse, hurt, use, lie, humiliate, or deceive them (Disbelief / Abuse scheme). Some people live with the belief that they are worthless, inferior to many, defective; they feel ashamed and embarrassed about what they consider to be unacceptable to them (Deficiency / Shame scheme).

Other people feel different from others and thus inadequate; as a result, they do not feel that they are adapted to any social group, nor do they manage to integrate.

From the perspective of psycho-sexology, people who have such active schemes can develop various disorders, from low sexual desire, vaginismus, erectile dysfunction (against the background of avoiding intimate relationships), to sexual preferences in the BDSM register, in which they look for abusive partners, situations in which he feels humiliated or degraded etc.

Area 2 - Autonomy and poor performance includes Dependency / Incompetence, Vulnerability to injury and illness, Interdependence / Childhood, Failure schemes

People who have one or another of the schemes specific to the field grew up in a hyper protective environment, in which they were not allowed to try, explore, differentiate and create their own identity; the parents did everything in their place, transmitting - without intending to do so - the idea of incapacity, undermining their self-confidence in their ability to do. There are great chances to develop schemes in this field and children who have not been cared for at all. People who have developed schemes in this field feel unable to do something without help from others, experience a general feeling of helplessness and, consequently, are passive, do not engage in activities, do not take the slightest risk. They feel inadequate compared to people of the same age, think of themselves as being bad, untalented, with no chance of achievement. They tend to merge with one of

the significant people, feel that I cannot live without the other. Other people have an exaggerated fear that something bad is about to happen (the appearance of a serious illness, a natural disaster, loss of control / madness).

In the field of psycho-sexology, they can develop a wide range of symptoms, from erectile dysfunction and premature ejaculation to paraphilic disorders.

Area 3 - Deficient Limitations Includes Delusions of Grandeur / Feelings of Justification, Reduced Self-Control / Reduced Self-Discipline

People who have schemes in this field grew up in too permissive families, without limits and rules. They tend not to respect the rules of discipline, the rights of others, do not cooperate, and do not respect commitments; they seem selfish, narcissistic, pampered, consider that the rules are only for others, they feel superior to everyone. Once they become adults, they restrain their impulses too little or not at all, they have a low tolerance for frustration, they cannot pursue long-term goals, they expect special benefits and privileges. They are demanding, dominant, weak or not at all empathetic.

Area 4 - Orientation to the other includes the schemes Subjugation, Self-Sacrifice, Need for Approval / Need for Recognition

People with these active cognitive patterns grew up in families where they felt accepted only if they met the demands of adults, if they hid / suppressed their desires, undesirable personality traits for significant people. As an adult, they seek the approval of others and do whatever it takes to get it; their choices are based on the reactions of others, their own needs are not realized and, even if they appear on the threshold of consciousness, the affective reactions corresponding to the need are not taken into account. Subjugation and Self-Sacrifice Schemes are very frustrating; the accumulated anger is not expressed directly, but erupts through passive-aggressive behaviors, fits of anger and / or psychosomatic symptoms. In the case of those who have an active Need for Recognition scheme, they value the reactions of other people rather than their own reactions, are overly concerned with accumulating money and / or success.

Area 5 - Hypervigilance and inhibition includes the schemes Negativism / Pessimism, Emotional Inhibition, Unrealistic Standards / Hypercriticism, Punishment.

People who develop schemes in this area often come from families where they have not been encouraged to play freely and happily, but have learned that life means a long series of negative events that they need to be aware of. They tend to select from the surrounding reality the negative aspects (death, disappointment, conflict, loss, suffering, etc.), they expect their life to take a negative turn at any time and they permanently experience the fear of not making mistakes that lead them to this (Scheme Negativism / Pessimism). Many of them do not express their emotions so as not to be criticized or to lose control and appear to be cold, expressionless, withdrawn (Emotional Inhibition Scheme). Other people set very high standards, followed by constant pressure and constant and exaggerated criticism of themselves and others (Schema Hypercriticism). „MUST!" it is quasi-permanent and governs their entire existence. For others, the mistake must be severely punished. They feel anger and intolerance towards themselves and others who do not meet certain standards and consider that harsh punishments are needed. He does not forgive mistakes, does not accept imperfection, does not take into account the way others see things and understand reality.

Cognitive patterns occur as a result of the frustration / dissatisfaction, during childhood, of some basic, universal emotional needs, felt with more or less intensity by an individual - the need for security, stability, to be guided, to be accepted as you are, the need for autonomy, the feeling of being competent / able to do things and having your own identity, the freedom to express needs and emotions, spontaneity and play, realistic limits and self-control. Reactions and responses of the family of origin, of the primary attachment figures, of the groups of congeners, of the caregivers, the behavioral models, the education viewed in a general sense etc. mediates the emergence and consolidation of these cognitive patterns.

A person in distress is a person who is not aware of the existence of this frustrated need and who, even if he/she sensed the needs, could not satisfy them in an adaptive way, because does not know how, and did not have adequate models the type and intensity of the need. In therapy, he/she identifies the central cognitive schema, but is also guided to identify ways to meet these needs in a way that meets individual expectations.

As mentioned above, cognitive patterns are factors of general vulnerability, which means that although two people may identify in their personality structure the same cognitive pattern, dysfunctional behaviors and associated emotions may be totally different, not only through subtle psychological processes of identification and counter-identification with one or another of the attachment figures, but also, mainly, through the intervention of intermediate cognitive structures (attitudes, assumptions and rules with a compensatory role).

For example, a central scheme of deficiency („I am bad, defective, unwanted, unlovable, inferior", „No one would love me if they knew my flaws", with feelings of insecurity when in the company of others, with feelings of shame etc.) can be expressed in intermediate cognitions such as: It is bad not to be wanted (attitude), If I say what I think, I will be rejected or If I do not say what I think, then others will appreciate me and accept me (assumption) or I have to be perfect and not make mistakes (rule with a compensatory role). In interacting with others, he/she may develop coping mechanisms of capitulation (enters into relationships with critical partners, who reject and, in order to be accepted, degrades), avoidance (does not express real thoughts and feelings and does not let others approaching) or overcompensating (criticizing, rejecting, doing everything to look perfect).

Identifying the cognitive schema and coping mechanisms are essential in therapy, and their recognition in the daily choices by the client is fundamental. An important element in therapy is the awareness that the coping mechanism, which became maladaptive, self-sabotaging in adulthood, was essential in childhood/ adolescence and helped the client cope with aversive events; but, once in adulthood, out of the situation of survival inherent in the child, the person has many alternatives to choose from, alternatives that can change the quality of life for the better.

Maladaptive cognitive schemas, as determinants, can be activated by any of the categories of factors mentioned above. They serve as a kind of filter through which the current life experience passes and which gives meaning to various events, transforming some of them into etiopathogenetic factors. Adaptive cognitive patterns evolve differently. „Some people show more psychological resilience and fail to develop strong maladaptive cognitive schemas, even in particularly aversive situations, unlike others who are more psychologically vulnerable and develop maladaptive cognitive schemas even if they have passed through an abuse of relatively low severity." (Young J., 2015).

Another set of determinants that contribute to the increase of vulnerability to the disease is the general and intermediate evaluative cognitive structures (David, 2015). The central irrational cognition is absolutist thinking (demandingness, for example, „I have to satisfy my partner every time!") accompanied by three intermediate irrational cognitions: awfulizing, for example, „My marriage will end because of my impotence!" or „It's awful what happens to me! ", low frustration tolerance (eg: "My current condition is unacceptable") and global evaluation. In therapy, the goal is to transform this absolutist thinking style into a rational one, by acquiring and practicing flexible thinking skills, expressing it in terms of preferences, not in terms of "absolutely absolutist need," accepting that what we wish it might not happen, non-catastrophic (accepting that no matter how bad you feel about an event/ aspect / problem, evaluating it as the worst thing that could happen is dysfunctional and false), tolerance of frustration (accepting that even if we don't like a situation and do what it takes for us to change it, failing that doesn't make it impossible to tolerate) and

contextual assessment, rather than global assessment (behaviors, actions of a people and their results do not label / define the person, this being in its essence valuable and, therefore, unconditionally accepted, but there are singular aspects that can signal the need to modify / optimize various particular aspects; for example, a weak or non-existent erection at some point may not make you „less of a man").

Local cognitive structures, in the form of dysfunctional automatic thoughts, are factors of local vulnerability and are part of the clinical picture of any sexual dysfunction. Disadaptive thoughts move easily from one role to another, and can be both precipitating and maintaining or even predisposing factors (through the meanings that the person can give to biophysiological / subjective reactions caused by automatic thoughts and the installation of a new vicious circle).

Labeling („I'm no longer a full man", „I'm flawed"), dichotomous thinking („If she doesn't have an orgasm, I'm nothing!"), overgeneralization („I'll never be able to satisfy her if I couldn't now"), maximalization („My wife will leave me because of my problem"), selective abstraction, „tunnel" vision, personalization are the main automatic thoughts described by A.T. Beck in 1976.

The transformation of central, intermediate and local cognitive structures into healthy, adaptive alternatives is the main goal in cognitive-behavioral therapy, postulating that, with their replacement, the intensity of emotions and/or psychophysiological/subjective reactions changes, and them in the adaptive register, the symptoms diminish. Of course, changes of a cognitive nature are desirable to be accompanied by learning new skills in interpersonal communication, problem-solving skills, learning relaxation techniques, etc., behavioral optimizations strengthening management skills at the cognitive level.

CONCLUSIONS

This paper wanted to reveal once again the complexity of the human sexuality, functional or non-functional, given that sexuality occurs at the intersection of biology, development and individual psychology, interaction with others, culture, education, environment, in the broadest meanings of notions. Each of these exerts a significant and consistent influence on the sexual becoming of the person and is very difficult, if not impossible to establish a hierarchy of these factors. Numerous studies (Delcea C, Enache A, Stanciu C); (Delcea C, Enache A, Siserman C,); (Gherman C, Enache A, Delcea C,); (Delcea C, Fabian A. M, Radu C. C, Dumbravă D. P,); (Rus M, Delcea C, Siserman C,); (Siserman C, Delcea C, Matei H. V, Vică M. L.); (Gherman C, Enache A, Delcea C, Siserman C,); (Delcea C, Siserman C,) confirm our results. In the therapeutic approach of sexual dysfunctions of a psychogenic nature, the complexity of the phenomenon makes it all the more difficult to establish precisely the causes that led to their occurrence. However, the thorough personal history, the most accurate identification of the possible psychological factors that contributed to the appearance of sexual dysfunction allow to adjust the focus in therapy, as well as to the awareness of therapeutic objectives, which gives the client the role of active participant and the feeling of gaining control over his own life.

Practice has shown that replacing an irrational style of thinking with a rational one, flexibility of thinking, optimization of interpersonal communication, awareness of self-sabotaging behaviours and the learning of healthy and adaptive behaviors, optimization of problem-solving skills, learning healthy ways of conflict resolution, psychoeducation, etc. increase the chances of success in overcoming sexual difficulties, not only those of a psychogenic nature, but also those with organic/physiological substrate, and, above all, contribute to an increase in the quality of life of the person.

BIBLIOGRAPHY:

1. Beck A.T. *Cognitive Therapy and The Emotional Disorders*, 1976.
2. Clark D.A., Beck A.T. *Terapia cognitivă a tulburărilor de anxietate (Cognitive Therapy of Anxiety Disorders)*, 2012.

3. Young J. E., Klosko J.S., Weishaar *Terapia centrată pe scheme cognitive – Manualul practicianului (Schema therapy: A practitioner's guide)*, 2015.
4. Porst H., Reisman Y. *The ESSM Syllabus of Sexual Medicine*, 2012.
5. Delcea C, Enache A. Individual Differences in Personality and Reasoning Traits between Individuals Accused of Murder and those who have not Committed Murder. Int J MentHealthPsychiatry 3:1. 2017. doi: 10.4172/2471-4372.1000140.
6. Delcea C, Enache A, Stanciu C, Assessing Maladaptive Cognitive Schemas as Predictors of Murder. Int J MentHealthPsychiatry 3:1. 2017. doi: 10.4172/2471-4372.1000142.
7. Delcea C, Enache A, Siserman C. The Reasoning Involved in the Decision Making Process of Individuals Who have Committed Murder. Int J MentHealthPsychiatry 4:1. 2018. doi: 10.4172/2471-4372.1000160.
8. Gherman C, Enache A, Delcea C. The multi-factorial determinism of forensic expertise regarding sentince interruption on medical grounds and decision. Journal of Forensicand Legal Medicine. Elsevier. 2019.Vol. 61, pp 45-55.DOI 10.1016/j.jflm.2018.10.005.
9. Delcea C., Fabian, A. M., Radu, C. C, Dumbravă D. P. Juvenile delinquency within the forensic context. Rom J Leg Med27(4)366-372(2019). DOI:10.4323/rjlm.2019.366.
10. Rus, M., Delcea C., Siserman C. The relationship between emotional distress and neuroticism at the operational personnel of ambulance services. Rom J Leg Med27(3)279-284(2019). DOI:10.4323/rjlm.2019.279
11. Siserman, C., Delcea C., Matei, H. V., Vică M. L. Major affective distress in testing forensic paternity. Rom J Leg Med27(3)292-296(2019). DOI:10.4323/rjlm.2019.292.
12. Gherman, C., Enache, A., Delcea C., Siserman C., An observational study on the parameters influencing the duration of forensic medicine expert reports in assessment of inmates' health status in view of sentence interruption on medical grounds - conducted at the Cluj-Napoca Legal Medicine Institute between 2014 and 2018. Rom J Leg Med27(2)156-162(2019). DOI:10.4323/rjlm.2019.156.
13. Delcea C., Siserman C. Validation and Standardization of the Questionnaire for Evaluation of Paraphilic Disorders. Rom J Leg Med 28 (1)14-20(2020). DOI: 10.4323/rjlm.2020.14.