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ANXIOUS SEXUAL FAILURE EXPECTATION SYNDROME (FEAR OF SEXUAL FAILURE) IN MEN

СИНДРОМ ТРЕВОЖНОГО ОЖИДАНИЯ СЕКСУАЛЬНОЙ НЕУДАЧИ У МУЖЧИН

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Abstract. Results of the article authors researches are submitted. It is reported that anxious sexual failure expectation syndrome (ASFES) can exist in two forms: the form of anxious apprehension of sexual failure as well as the form of fear of sexual failure (coitophobia). Three variants in the formation of ASFES (premanifest, manifest, postmanifest with respect to the beginning of sexual dysfunctions) are isolated as well as its acute, subacute and gradual development. Some mechanisms of its pathogenesis are revealed (dysfunction of mesodiencephalic structures, which occurs during intimacy, hyposecretion of testosterone, weakening of its transformation into dihydrotestosterone, hyperprolactinaemia, etc.), and its sexological and nonsexoligical manifestations are characterized (sexual dysfunctions, psychoautonomic and psychosensory disturbances, behavioural changes during and outside intimacy). Types of “neurosis of failure expectation” are submitted. Variants of the ASFES course (continual and alternating) and its clinical variants (total, selective, androcentric, feminocentric and mixed) are isolated. Also, different variants of the ASFES influence on sexual harmony (decompensatory, compensatory and the one that does not have any significant effect on the harmony) and common information about therapy for this syndrome (psychotherapy, pharmacotherapy) are submitted.

Аннотация. Приведены результаты исследований автора статьи. Сообщается, что синдром тревожного ожидания сексуальной неудачи (СТОСН) может существовать в форме тревожного опасения сексуальной неудачи, а также в форме страха сексуальной неудачи (коитофобии). Выделены три варианта формирования СТОСН: доманифестное, манифестное и постманифестное по отношению к возникновению сексуальных дисфункций, а также острое, подострое и постепенное его развитие. Вскрыты некоторые механизмы его патогенеза (дисфункция мезодиэнцефальных структур, которая имеет место во время интимной близости, гипосекреция тестостерона, ослабление его превращения в дигидростерон, гиперпролактинемия и др.) и охарактеризованы его сексологические и несексологические проявления (сексуальные дисфункции, психовегетативные и психосенсорные расстройства, изменения поведения во время и вне интимной близости). Представлены типы «невроза ожидания неудачи». Выделены варианты течения СТОСН (континуальный и альтернирующий) и его клинические варианты (тотальный и селективный, андроцентический, феминоцентрический и смешанный). Также приведены различные варианты влияния СТОСН на сексуальную гармонию (декомпенсирующий, компенсаторный и такой, который не оказывает сколько-нибудь значимого воздействия на указанную гармонию) и общие сведения о лечении данного синдрома (психотерапия, фармакотерапия).

Keywords: anxious sexual failure expectation syndrome, men, formation, pathogenetic mechanisms, clinical manifestations, therapy.

Ключевые слова: синдром тревожного ожидания сексуальной неудачи, мужчины, формирование, патогенетические механизмы, клинические проявления, терапия.

In 2013 one of authoritative professional Ukrainian journals published in the Russian language our article that was dedicated to summarizing data of my researches on fear of sexual failure in men [1]. Due to the importance of materials, stated in it, we have considered it rational to publish them in the English language in this journal, which is widely represented in international scientometric databases.

"Anxious sexual failure expectation syndrome" (ASFES) is one of the most frequently diagnosed and universal sexopathological syndromes in sexological help–seeking males. This was thoroughly studied in the USSR in the second half of the 1980 s — the beginning of 1990 s [2–4]. ***In the Western literature ASFES is known as "fear of sexual failure"***. Apprehension/fear to be unable to carry out or complete a sexual intercourse is the essence of the above syndrome. This anxiety/fear is maximally expressed in the circumstances of intimacy, resulting as a rule in disturbances of sexual functions because of their disautomatization.

ASFES can exist in two forms: ***the form of anxious apprehension of sexual failure***, which is characterized by obsessive thoughts about possible sexual failure and hypercontrol of the penile tension (if this anxiety concerns predicted erectile disturbances), as well as ***the form of fear of sexual failure (coitophobia)*** [5], which is characterized by a more expressed presentation of the emotional component and accompanied with the autonomic disturbances that we have described (see below). In this form, when the patient's prediction of his erectile disturbances is in question, pronounced hypercontrol of his penile tension is present too. It is necessary to bear in mind that the term "coitophobia" should not be reduced only to a fear of ending in a fiasco during an attempt to carry out a sexual intercourse, it forming the basis of the fear to have it. Coitophobia can also be caused by other factors [5].

In those males, who seek sexological help, ASFES is most commonly diagnosed in patients with neurotic disorders, the majority of these cases having the so-called neurosis of failure expectation (in ICD-10 it belongs to sections F40.1 and F42). At the same time this syndrome is diagnosed in some personality disorders (psychopathies) too, as well as in patients with endogenous mental pathology, e.g. in schizophrenia. Besides, ASFES often aggravates the course of sexual disorders, which were initially caused by somatic pathology.

Variants of formation, initiation

As our researches demonstrate, there are three variants in the formation of the above syndrome [2, 6, 7]. In the first case, its appearance precedes the development of sexual disorders ***(premanifest formation)***. In the second one, the first sexual contacts with new female partners are sure to be accompanied with an anxious expectation of failure with resultant copulatory "failures". Nevertheless subsequent coituses with the same women pass without any defects, because rather rapidly ASFES is eliminated ***(manifest formation)***. The third variant is characterized by the development of the above syndrome after the appearance of sexual disorders ***(postmanifest formation)***. In the majority of patients with the last variant of its formation ASFES develops acutely or subacutely (after one or several unsuccessful attempts), in the minority gradually (since the moment of appearance of sexual disorders a rather long period of time passes: from one month to a few years).

The development of ASFES can be initiated by a fear of consequences of masturbation (very seldom at present); physiological fluctuations of sexual functions; temporary weakening of potency caused by physical and mental overstrain, use of alcohol; situation–caused sexual dysfunctions

(having intimacy in unsuitable circumstances); an inadequate assessment of normal parameters of one's sexual functions; a negative assessment of the male's sexual qualities by his female sex partner (reproaches, insults); presence of true sexual disorders, caused by another kind of pathology; and many other factors [2, 6, 7].

Among internal causes that contribute to the appearance of this syndrome we should mention, in particular, anxiety–hypochondriac character traits, which are observed in some accentuations of character and personality disorders (psychoasthenic and sensitive accentuations, anankastic personality disorder). In some cases it is internal factors that provoke, while exogenous (psychogenic) ones only facilitate the development of ASFES [2, 6, 7].

Pathogenesis

Our researches in studying the pathogenesis of sexual disorders in patients with neurosis of failure expectation [2, 6] have shown that the appearance of such disorders takes place with the participation of disturbances in the central nervous system caused by dysfunction of mesodiencephalic structures, which occurs during intimacy. Development of these disorders can be influenced by hyposecretion of testosterone, weakening of its transformation into dihydrotestosterone and hyperprolactinaemia [2, 6, 8,]. Also a psychological model of the formation of ASFES (G. S. Kocharyan, A. S. Kocharyan, 1986) exists, substantiating its development from the positions of psychological functional systemic mechanisms. Earlier authors suggested models, which explain the development of sexual dysfunctions caused by the above syndrome on the basis of I. P. Pavlov's neurodynamic conception, the doctrine of a dominant by A. A. Ukhtomsky (S. I. Groshev, 1967), Mowrer's two–factor theory (G. Kockott, 1980), as well as P. K. Anokhin's theory of functional systems (S. T. Agarkov, 1984) [6].

Sexological symptoms

Our clinical studies have revealed the following facts. Of all sexological symptoms in cases of the neurosis of failure expectation such patients most frequently suffer from erectile disturbances (hypoerection, anerection, unstable and undulating erection, the torpid appearance of penile tension), ejaculatory disturbances (premature ejaculation in the overwhelming majority of cases) being less common. Diminished libido is slightly less frequent than ejaculatory disturbances, and very seldom mild hypoorgasmia is observed. These symptoms can exist separately and in various combinations [2, 6, 9–11].

The above neurosis affects both adequate and (in more manifested cases) spontaneous erections (daytime, morning, nighttime ones). Of spontaneous erections, nighttime ones are the most unaffected, since it is at this period that expectation of failure and hypercontrol or penile tension, associated with this expectation, are either absolutely absent or minimally manifested [2, 6, 9–11].

Besides the above copulatory disturbances half of the patients reveal the symptom of sexual hypoesthesia–anesthesia, which manifests itself with a partial or complete blockade of voluptuous sensations felt in the case of fleshly intercourse with a female partner during intimacy [2, 6].

The intensity of apprehension/fear of sexual failure undergoes changes even during short periods of time, naturally having an impact on sexual functions. Thus, this intensity decreases in subwaking and postsubwaking states and, therefore, in some cases can result in high–quality coituses in night and morning hours. Besides, unplanned coituses are often more valuable than planned ones and sometimes even perfect, because in the first case the above apprehension/fear either does not have enough time to be "turned on" in full measure or to be "turned on" at all [2, 6, 9–11].

We have separated the following symptom forming factors, which take part in the formation of copulatory disturbances in patients with neurosis of failure expectation: 1) "semantic field" (semantics) of apprehension of failure, which characterizes what particular sexual disorders are predicted by the patient (erectile, ejaculatory, or may be both); 2) emotional strain; 3) hypercontrol of sexual functions; 4) sexological symptoms, initially caused by another kind of pathology, which

is superimposed by an aggravating impact of ASFES; 5) personality responses to a sexual disorder; 6) sexual dysrhythmia; 7) basic symptoms, which cause development of their derived copulatory disturbances (for example, hypoerection can result in prolongation of coitus or even anejaculation). The first four of the above factors are specific for ASFES, whereas others are not and can participate in the formation of copulatory disturbances in any other forms of sexual disorders [2, 6, 10].

In the majority of males their neurosis of failure expectation leads to the development of sexual disorders and always takes the crucial place in their structure. In the minority of patients this neurosis aggravates the course of sexual disorders, which were initially caused by other factors, and more frequently plays an auxiliary part in their organization [2, 6].

Nonsexological manifestations

As our researches demonstrate, in the circumstances of intimacy patients with the neurotic expectation of failure develop psychoautonomic disturbances, which in the case of coitophobia can be in the form of situational paroxysms and subparoxysmal states of the sympathetic–adrenal or mixed character. Sympathetic–adrenal paroxysms and subparoxysmal states manifest themselves with tachycardia, chill and rigor–like hyperkineses. Unpleasant sensations in the heart region and behind the breastbone occur very seldom. In the case of mixed autonomic paroxysms and subparoxysmal states the patients have, besides the above phenomena, difficult inspiration accompanied with the feeling of air shortage, abdominal murmur, defecation urges, increased sweating, and seldom — urination urges and hot flashes [2, 6, 12].

We have revealed that during intimacy patients with this neurosis have various psychosensory disturbances (in the head, trunk, extremities, genital organs) [2, 6, 12].

Besides the above symptoms, all day long males with neurosis of failure expectation are often haunted by thoughts of sexual incapacity. They can also develop different manifestations of the asthenic syndrome as well as a bad mood, which sometimes reaches the level of subdepression or even depression. Some patients demonstrate advanced hypochondria, reticence, high jealousy, compliance, taciturnity and pensiveness, which were not present before the development of the pathology in question, are dynamic in character and smoothed down after elimination of sexual problems [2, 6].

We have revealed that very often during and outside intimacy patients with neurosis of failure expectation develop various behavioral changes. In the first case they use techniques of mental self-regulation of sexual functions: autosuggestion, attention changeover, erotic autosensitization. The latter often consists in an autosuggestion–mediated increase of fleshly intercourse perception of specific stimuli during intimacy, this increase being achieved by the concentration of the patients' attention on the pleasant sensations they feel. These techniques are aimed at fighting anxious apprehension of failure or directly at improving sexual functions. Different degrees of effectiveness of using the above techniques in different periods of time are observed approximately in half of the males [2, 4, 6, 13–15].

As our researches have shown, behavioral changes in patients with the neurosis in question outside intimacy are diverse and differ by the degree of complexity and awareness. These can be as follows: exclusion of communication with women on the sexual, erotic or even platonic level; hypertrophy of previous hobbies or appearance of new ones, intensification of studies, preoccupation with job and involvement into voluntary works (sublimation); different variants of depreciation of women achieved by means of the work of the psychological defense mechanism; compensation of one's sexual incapacity by paying more attention to his spouse and helping her in carrying out household tasks, as well as striving to replenish the family budget with additional earnings. For the purpose of elimination of sexual disorders, in some cases males on their own initiative give up drinking spirits, smoking and become engaged in different health–improving systems. Many other behavioral transformations are registered too; for example, alcoholization [2, 3, 6, 14, 16–18].

Neurosis of failure expectation as a diagnostic concept

It should be noted that there are two alternative conceptions of the so-called expectation neurosis (A. M. Sviadoshch, 1982). According to the first of them, an expectation neurosis is an independent form of neurosis, while in compliance with the second one this is a specific kind of obsessive–compulsive neurosis. During our special clinical–psychological examination of patients with neurosis of failure expectation we managed to separate its 8 types [2, 6, 19, 20]. This separation was based on such criteria as awareness of morbidness of anxious apprehension/fear of sexual failure, its pathogenic influence, as well as the presence of fight against it. As result of our analysis we have drawn a conclusion that this neurosis is some continuum. One of its poles contains forms with the absence of the signs, typical for obsessive–compulsive neurosis, while the other pole has variants, which manifest these signs in full measure. As if the above continuum demonstrated a process of gradual accumulation of qualities, inherent to neurosis of failure expectation. The question arises, what can explain the fact that in spite of the presence of pathogenic influence of anxious expectation of failure on the sexual sphere and general condition rather often are absent such signs as alienation of apprehension for the contents of thinking, as well as a critical attitude to this apprehension. In our opinion, one of the causes for its explanation consists in the specificity of such a behavioural act as intimacy. Hence, for example, if the absurdity of such phenomena as agoraphobia and others for patients is absolutely obvious, the anxious expectation of failure in some cases can be perceived as a natural response to true or imaginary sexual incapacity. This is also facilitated by such variants of the development of ASFES, when the latter aggravates the course of sexual disorders, caused before by another kind of pathology, thereby making the process of the patient's orientation in his own condition even more difficult. According to our observations, the absence of the awareness of morbidness of anxious apprehension/fear of sexual failure and fight against it does not actually mean that it is not obsessive by nature. Thus, in a number of cases the appearance of such awareness and hence the wish to get rid of the above expectation did not result in the elimination of this expectation. On this basis, we can conclude that in some cases obsession may be unconscious. So, which of the two alternative viewpoints on expectation neurosis, described above, is correct? Is this an independent form of neurosis or a specific kind of obsessive–compulsive neurosis? In our opinion, each of the above points of view is partially correct and has the right to exist. While advocates of the first one can rely in their argumentation on the fact that many patients from this category do not have all or some signs, which are obligatory for obsessive–compulsive neurosis, advocates of the second one can with good reason cite as an example those cases, which by their characteristics are sure to have the above neurosis. On the basis of our researches the latter advocates also have the right to plead the possible existence of unconscious obsessions. Nevertheless there is always a problem with making a diagnosis. We believe that it is hardly reasonable to put patients of the sexological type with the pathology in question into different classification items. In all cases, which of the viewpoints would the physician support, it seems that he should diagnose "neurosis of failure expectation", which was described in the pathogenetical classification of sexual disorders in males by G. S. Vasilchenko (1977) [2, 6, 19, 20].

Clinical variants and course

The results of our researches show that the course of the neurosis of failure expectation has its ***continual and alternating variants*** [2, 6, 21]. In the former case ASFES exists during some definite period of time actually constantly, while in the latter one ASFES at one moment disappears, at another moment appears again. In its both continual and alternating variants of the course of this neurosis ASFES can be both ***totals*** (be manifested during intimacy with any woman) and ***selective*** (be expressed only towards the definite female partner). In the latter case, sexual intercourses with other women pass without any defects.

As it was mentioned before, we have also revealed such a variant of ASFES, which can be called the ***anxious sexual failure expectation syndrome of the initial period*** [6]. It concerns those cases when the anxious expectation of failure invariably appears during one or several first sexual

intercourses with a new female partner, but in the process of becoming accustomed to her is rapidly eliminated together with the sexological symptoms, which it has caused. Thus, for example, in one of out patients this phenomenon was observed during 15 years.

We have also separated the ***androcentric variant*** of ASFES (the male is anxious about only his own sexual problems), its ***feminocentric variant*** (the patient is mainly anxious about the woman's feelings and her state owing to his sexual disorder) and ***mixed variant***, which combines characteristics of both previous ones. It should be noted that the androcentric variant of ASFES is characterized by a higher severity versus the feminocentric one [2, 6, 21].

The character of the course of the neurosis of failure expectation depends upon personality traits and partner situation. Thus, for instance, if the patient has streaks of anxious hypochondria plus quarrels and conflicts in his family (first of all on the sexual grounds), it creates prerequisites for a long–term progressive course of the above neurosis with a tendency to become continual and total.

Our analysis of sexual communication in married (partner) couples, when neurosis of failure expectation is diagnosed in men, demonstrates that there is the ***decompensatory*** and, though rather paradoxically, ***compensatory*** variants of the influence of sexual disorders, where the neurosis in question is diagnosed, on sexual harmony. The latter variant of the above influence is seldom observed and caused by some prolongation, on the patient's initiative, of the preliminary period in order to increase his erection with a resultant orgasm in the female partner, which she had not experienced before the sexual disorder developed in the male. If ***there is not any significant influence of sexual disorders on the characterized harmony*** we can state that before their appearance women did not experience an orgasm during sexual intercourses either. In a number of other observations the absence of this influence was associated with a slight manifestation of copulatory dysfunctions in males. In these cases women feel an orgasm as often as before and no frequency imbalance in the need of sexual contacts in both partners develops [2, 6].

In women with sexual disorders ASFES, including that of the neurotic genesis, is diagnosed much more seldom than in males. It is usually manifested by the apprehension of inability to experience an orgasm another time.

Treatment

Treatment of patients with ASFES of the neurotic genesis presupposes the use of psychotherapeutic techniques and biological therapy. In this pathology, psychotherapy should be regarded as prevailing. Psychotherapeutic influence is realized through techniques of explanatory, rational, cognitive, rational emotive and positive therapy; these are directed at an explanation of mechanisms of sexual disorders, correction of the scale of feelings and training in constructive modes of thought in the given situation. In this connection it is possible to mention such techniques, suggested by us, as "false signal", "extension of consciousness", "comparison by analogy", "decrease of the rank of significance of sexual disorders", "psychotherapy with regard to the mechanism of projection", etc. [22].

In order to treat patients with the above pathology the following techniques are used: autosuggestion, including contrast one; autogenic training (including its accelerated variant, which we developed for treating sexual disorders — G. S. Kocharyan, 1987, 1988, 1991); hypnosuggestive therapy (hypnosuggestive programming and modelling); neurolinguistic programming: "the method for correcting of behavioral programs" (G. S. Kocharyan, 1992, 1994), the method of "explosion of obsession (obtrusiveness)" (K. Andreas, S. Andreas, 1994) adapted and tested by us for treating patients with ASFES (G. S. Kocharyan, 2001), the technique of "sway" (R. Bandler, 1994); special techniques used for eliminating the fear of sexual failure: "imaginary prohibition" ("forbidden fruit"), "honeymoon" (K. Imieliński, 1974) and "gynecological position" with psychotherapeutic effect (K. Imieliński, 1971,1974), "verbal liberation" (S. I. Groshev, 1967), "open–hearted confession" (S. Kratochvíl, 1985), "safeguard" (A. M. Sviadoshch, 1982), "emotional–stress self-suggestion with use of the ideomotor pendular test" (A. V. Grishin, 1988), therapeutic petting (S. V. Vladimirov–Kliachko, 1972; S. S. Liebich, 1990), the "system of erotic

sensitization" (G. S. Kocharyan, 1987); the cognitive–behavioral "thought stopping technique" (J. A. Bain, 1966); Francine Shapiro's "technique of desensibilization and processing by movements of eyes" (1988); sex therapy techniques, which by the mechanism of their action should be put into behavioral therapy, etc. [2, 6, 14, 23].

Owing to the fact that intimacy is a paired behavioral act and its quality depends on to a large extent upon each of its participants, wives (sex partners) should be engaged as co-therapists. Here it is necessary to take into consideration that sexual technique is not the only factor, which produces its effect on the quality of sexual contacts. This quality is significantly influenced by psychological relations between the man and woman. In this connection such a kind of psychotherapeutic techniques as conjugal therapy is used. In those cases when relations between the spouses form with the participation of other members of the family, it becomes necessary to use family therapy. Recommendations also exist for using group therapy, but the latter is rather seldom used for the pathology in question.

In order to treat ASFES of the neurotic genesis, medicinal treatment and physiotherapy (for example, local decompression of the penis with its resultant considerable enlargement, which can produce a manifested psychotherapeutic effect) are used. The medicines include mainly tranquillizers and much more seldom mild neuroleptics, administered in small doses. It is recommended to take individually selected doses of these drugs approximately 1–2 hours before intimacy. In case of manifested general neurotic symptoms, observed outside the above intimacy too, it becomes necessary to administer a course of medicines from the groups, listed before, as well as use adaptogens, antidepressants [mainly selective serotonin reuptake inhibitors, in particular trazodone or its analogs] (in a manifested bad mood), drugs influencing metabolic processes in the brain (nootropics), and other medicinal agents. It should be noted that antidepressants, serotonin reuptake inhibitors, are widely used in psychiatry for treating anxious–phobic disorders too.

It is necessary to point out that medicinal treatment and physiotherapy must be psychologically reinforced, thereby increasing their therapeutic effect.

At present, owing to revolutionary discoveries in pharmacology (sildenafil citrate, vardenafil, tadalafil), treatment of patients with ASFES has become more effective. Taking of these medicines some time before the coitus in combination with tranquillizers, and sometimes even without them, can provide high–quality coituses, which by themselves in certain cases can result in a reduction of ASFES.

It should be especially emphasized that rather common are sexual disorders of mixed etiology, when ASFES is only one of the structural components, which take part in the organization of an integral sexual failure. Naturally, in these cases the scope of biological therapy significantly increases.

We would especially like to dwell upon possible recommendations for treating patients with the selective variant of ASFES in those cases, when there are no sexual difficulties with the wife, but these exist in extramarital relations. Some physicians may take the position of a moralist and refuse treatment to their patient on the basis that no extramarital relations must be. Others may tell the male that he is not able to be a lover. In our opinion, to proceed from the postulate that the family is firm in all cases (whatever could happen and how bad the relations between the spouses could be) is an abstraction, which is not confirmed by the reality. But even when it concerns the relations, which are of little importance for the patient, he should not be suggested that he is not able to be a lover (for example, as a result of his weak sexual constitution). Besides the appearance of the inferiority complex, nothing else can be achieved with such influences. It would be more correct in the above cases to explain the fiasco with the newness of the situation and change of the female partner as well as, maybe, with a feeling of gilt. We think it reasonable to give the male a possibility to realize his needs, if the relation with this female partner is significant for him and what is more situationally justified, and then act as he himself considers it necessary. The patient's giving up of extramarital relations should be realized proceeding from the position of sufficiency rather than that of inability [6].

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