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PATTERNS OF BEHAVIOUR IN MEN CAUSED BY SEXUAL DYSFUNCTIONS

ПАТТЕРНЫ ПОВЕДЕНИЯ У МУЖЧИН, ОБУСЛОВЛЕННЫЕ СЕКСУАЛЬНЫМИ ДИСФУНКЦИЯМИ

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Abstract. On the basis of special scientific researches and clinical observations the following patterns of behaviour outside intimacy in men with sexual dysfunctions were distinguished and described: 1) avoidance; 2) directed on preservation of the former matrimonial status (the compensatory variant, the manipulative variant); 3) directed on creation of the image of a man with a strong sexual potency; 4) sublimation and behavioural changes, which are phenomenologically close to it; 5) directed on elimination of the sexual disorder; 6) asthenical; 7) subdepressed–depressed; 8) spreading of fear into the situations, which are not connected with intimacy; 9) loss of initiative in establishing of attitudes to women, specific restrictions at a choice of a sexual female partner; 10) behavioural transformations caused by dynamic shifts of character's traits; 11) hyposexual; 12) hypersexual.

Аннотация. На основании специальных научных исследований и клинических наблюдений выделены и описаны следующие паттерны поведения вне интимной близости у мужчин с сексуальными дисфункциями: 1) избегающе–уклоняющийся; 2) направленный на сохранение прежнего супружеского статуса (компенсаторный и манипулятивный варианты); 3) направленный на создание образа мужчины с высокой сексуальной потенцией; 4) сублимация и феноменологически близкие ей поведенческие изменения; 5) направленный на устранение полового расстройства; 6) астенический; 7) субдепрессивный–депрессивный; 8) распространение страха на ситуации, не связанные с интимной близостью; 9) утрата инициативы в установлении отношений с женщинами, специфические ограничения при выборе партнерши; 10) трансформации поведения, обусловленные динамическими характерологическими сдвигами; 11) гипосексуальный; 12) гиперсексуальный.

Keywords: men, sexual dysfunctions, behaviour, patterns.

Ключевые слова: мужчины, сексуальные дисфункции, поведение, паттерны.

In 2005 one of authoritative professional Russian journals, which unfortunately ceased to exist long ago, published in the Russian language our article that was dedicated to behavioural changes caused by sexual dysfunctions. Virtually, the article was not represented in international scientometric databases. 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 the above databases.

During examination of patients with sexual dysfunctions the physician usually concentrates his attention on revealing their copulatory disorders, but leaves without sufficient attention their behaviour changes, whose development in these patients results from the above disorders outside intimacy. This approach substantially contrasts with fixation of attention on the behavioural pathology in people with disorders of sexual identification, sex–role behaviour and psychosexual orientation. The above is caused by the fact that behavioural disorders in these categories of patients are essential for them and, quite naturally, get into the epicentre of the researchers' interest [2, 3, 4, 5]. Here it is the matter of the so–called sexual behaviour.

At the same time it should be noted that significantly prevailing among the males, who seek sexological advice, are patients with some copulatory dysfunctions (hypoerection, premature ejaculation, etc.). Nevertheless the behavioural changes, caused by the above dysfunctions, did not become the subject of an independent study. One can reveal only separate remarks on this problem in special literature as well as isolated publications, which deal only with some particular aspect in behavioural changes, caused by sexual problems. Thus, for example, Kaplan H. S. [6] examines the problem of sexual avoidance as a manifestation of intrapsychic barriers with respect to emotional intimacy. It is supposed that in some cases this avoidance is a distinctly clear function of the above barriers, while in others it results from other determinations, such as excessive requirements of the partner to intimacy and communication or his/her intolerance even to a normal emotional distance. Westphal C. [7] interprets avoidance behaviour as a response to a sexually provocative situation, which is expected. This behaviour is characterized by phobias. He mentions "transparency" of the unrecognized continuing struggle that makes the woman unattractive. Obesity and anorexia–caused leanness, which destroys women's body shapes, are unrecognized attempts to camouflage female shapes in order to avoid male sexual arousal. The author also notes that vaginism is unconsciously aimed at creation of an obstacle for appearance of the above desire. Female's avoidance behaviour is discussed in this article in terms of "body" experiences, fantastic representations and dialectics of libido.

Citrenbaum Ch. et al. [8] report a case with a single 31-year–old woman, who was 155 cm high, but weighed 96 kg. Her body weight during her childhood and adolescence was normal, but since the age of 16 she began to grow stout fast and suffer from obesity. As it turned out, immediately before she started putting on weight she had been raped. That fact aroused her anger and fright. Her therapeutist supposed importance of a hidden advantage of stoutness that made the woman unattractive, thereby protecting her from sexual assaults and helping to feel more secured.

It can be asserted that only a pronounced libido increase or, on the contrary, its significant reduction, both of which generate easily predictable behavioural changes, are rather well described in special literature. But any physician, who sees general sexology cases, can state that among the patients, whom he consulted during all his medical practice (even for a large number of years), cases with hypersexuality are so rare that can be even counted on one's fingers. And this observation concerns mostly women.

Analysis of our findings, received earlier during special clinical–psychological studies of behaviour in males, who had some or other copulatory disorders and were diagnosed to have various forms of sexual disorders [9–13], current researches [14] as well as clinical observations (representatives of both sexes are in question) reveal that men have different patterns of behaviour, caused by the above disorders. Anxious sexual failure apprehension/fear was the invariable, and in the majority of cases the main (sometimes even the only) factor for the development of sexual dysfunctions in all the men, who underwent the special examination. The revealed behavioural transformations were characterized by different complexity and realized by the patients completely or partially, or not realized at all. We have distinguished the following main patterns of behaviour.

Avoidance

This is characterized by the fact that the patients avoid contacts with women on the sexual (making cotuses less frequent or excluding them at all), erotic (excluding caresses and kisses) and

even Platonic levels (without establishing any more or less stable relations with representatives of the female sex). In some cases, when the intercourse reaches the verge of sexual interaction, it does not move further than alleged attempts.

Sometimes patients with sexual disorders contact with such representatives of the female sex, who make no sexual demands owing to the force of various circumstances (for example, they may be very young). Pseudosubstantiation of their behaviour helps the patients to maintain their intercourse on the erotic or even Platonic level. Thus, one of our patients used to kiss and embrace his bride and even regularly sleep together with her at night but did not have any coituses with her. Answering her questions why he did not do it he used to say that if it happened he would brake off with her. Another patient for a long time dated a woman whom he liked very much, but despite a prolonged period of their acquaintance he never took her in his arms and kissed. When at last she asked him why he acted so, he answered that if he did it he might immediately dislike her. After that explanation the woman ceased to date him at once. It is not in rare cases that rationalization is engaged and then the patient substantiates his reduced or absent sexual activity, for example, by a little expediency of a sex life since the latter allegedly attracts people away from solving other, "more important" problems ("It has not turned out as it should be, but there is nothing to worry about, it is not worth of being sorry"). It is fair to say that in many cases the patients themselves do not entirely believe in the version they give. At the same time even in the mentioned cases, nevertheless, it helps them as it reduces their psychic tension. Below is an example of pseudosubstantiation of his behaviour and specific motivation in the choice of the girl, whom our examined male dated.

Patient B., 21 years old, single. Diagnosis: neurasthenia with sexual failure expectation syndrome in the personality, who is accentuated according to the psychasthenic type: hypoerection sign. At present he dates two girls of different age. One of them is 17. She is from his village, but now studies in the city and periodically arrives home. He notes that he has had up to 10 alleged attempts with her. When they embrace, his penis is fully erected only seldom. This girl tries to seduce him to sexual contacts herself. She says that she loves him. But he allows himself everything, besides the above contacts, because when he approaches the decisive moment, his erection disappears at all. He explains his behaviour to her in the following way: if "it" happens, she will "become too spoiled" in the city. Nevertheless he promises her that when she finishes her technical secondary school and returns to the village they will begin living a sex life. But it does not suit her, as she wants to be like other people. Besides this girl he also dates another one, who is only 15. During embraces and kisses with her his erection is good. He does not make any (even alleged) attempts to have a sexual intercourse. He likes the both girls almost to the same degree, but still more the latter one. The first girl knows that besides her he dates another one and demands that he put an end to those dates. He promises that he is sure to do that as soon as she finishes her technical secondary school. We have managed to find out that his motivation for dating the second girl is significantly caused by the fact that owing to her age he may not be concerned about a necessity to have a coition. During an intercourse with her he feels quieter, with resultant positive effects on both the quality of erection and his general state.

Our clinical observations indicate that patients of the sexological type often resort to various tricks that help them to avoid such situations, which are threatening in the aspect of a possible sexual intercourse. In some cases the patients even deliberately provoked quarrels with women and sometimes it resulted in breaking off all their relations. Thus, for example, one of our patients tried to quarrel with his bride in order to disrupt their expected wedding. Next is a very significant example of the behaviour, which provokes a quarrel.

Patient M., 23 years old, single. Diagnosis: neurosis of failure expectation (fear of sexual failure). In the process of our purposeful questioning we managed to reveal that every time when his dates with women began rather prolonged in the sense that a natural change from the erotic level of relations (caresses, kisses) to the sexual one (coitions) was already supposed he simply broke his next appointment. Dating women, among whom he was a success due to his outward appearance,

and wishing to break off their relations he started conversations unpleasant for them. He used to say something like this: "Just think, your husband trusts you, but you are with me and looking for a place where we could ..." Usually one such remark was enough for the woman to feel hurt by him. As a rule it was followed by a break–off in their relations. Once, in order to break off dates with one woman, he broke his appointment. Some time later he met her by chance. They went in the same bus. The woman did not pay any attention to him. As soon as she left the bus the patient came up with her, and they got into a conversation. When the woman forgave him the offence and the tension passed, he told her the following words in order to provoke a quarrel again, "When you went out of the bus, you turned away from me and even did not greet me, but now you are walking and laughing. Instead of this you might not laugh, but go on walking, as you did before."

In a number of observations among the studied category of patients there was disappearance of any sympathy for the female partner. They did not like her any more as suddenly they revealed some difference in their views on life, etc. (switching on of the mechanism of psychological defence). In these observations a reduction of the psychic tension was achieved through different variants of the woman's depreciation. Below is an example of a very uncommon variant of such depreciation.

Patient V., 64 years old, single. Diagnosis: mixed personality disorder (mosaic psychopathy) with the syndrome of sexual failure expectation against a background of chronic prostatitis, hypoerection sign. Since the above syndrome originated long ago, with time he has developed a fixed (an obsessive image whose expression is as follows. Every time when he sees pretty women he imagines how they use lavatory paper after defecation, and it excites disgust in him. But he had repeated rectal contacts with women in the past; those contacts aroused great excitement and gave him intense delight.

There is no doubt that in this case the fixation results from the work of the psychological defence mechanism, which prevents an increase in the psychic tension thereby blocking a possible development of relations with women at the earliest stages.

It is not in rare cases that the patients avoid even conversations on sex subjects rather than only any contact with women at different levels of interaction (sexual, erotic, Platonic), since the mention of strong males and those with a weak potency produces a psychotraumatic effect on them. For this reason they sometimes avoid parties where such conversations may take place and give up inviting other people to be their guests. In some cases, for the above reason, the sex subject becomes forbidden in talks had by the spouses as well as sexual partners, who have not officially formalized their relationships.

Sometimes the mechanism of avoiding of the psychotraumatic effect of situations, connected with feelings of sexual inefficiency, came out in an inclination to change places of residence in order to exclude meetings with those women, with whom the patients had intimacy before.

In some cases anxious apprehension/fear of sexual failure causes a significant delay in the terms of marrying. Sometimes males never make up their mind to marry. In a number of cases even curious incidents can be observed, when there are no real grounds for the above apprehension/fear, but its origin is entirely caused by incorrect information awareness of the patients.

In the analysis of the problem of avoidance behaviour the latter should also include behavioural manifestations of sexual aversion as well as such relative pleasantness/desirableness mechanism–caused phenomena in females as hysterical dyspareunia (hysterical genitalgias), vomiting and urges to vomit during coituses and immediately after them, cystalgia after sexual intercourses, frequent prolonged and painful menses in the wife when her spouse is in the family, passage of flatus in the husband when he sleeps in the same bed with his wife. The above circumstances block execution of the coitus, whose bad quality, caused by early ejaculation, every time results in a negative response from the wife's part. It should be noted that all these phenomena are based on unwillingness to have intimacy with one's (more often definite) partner.

Our following clinical observations can serve as examples.

Thus, a woman, who was at a neurological in–patient department with diagnosed encephalitis and liquor–hypertension syndrome, was sent to the psychotherapy room because of her asthenic state. In the process of her history taking it was revealed that after each coitus she developed vomiting. Sexual arousal during coitions was absent. It turned out that the development of her neurological pathology was gradually accompanied with sexual dysfunction, which at the moment of her admission to the hospital manifested itself with affection of all phases of the copulation cycle. She did not feel any need of intimacy, but had to make coituses, because her husband told her over and over again something like this, "If you don't want to live a sex life with me, it means that you have a lover".

The second example concerns a woman, who sought our sexological advice complaining of constant pains in the area of her clitoris; she had consulted about those pains gynaecologists with different levels of proficiency (up to the highest one) in different cities of Ukraine. None of the above specialists found in her any organic grounds for her pains. On examination we revealed that the woman had bad relations with her husband and a pronounced hysterical characterological radical with associated falsity.

But in cases with persistent sexual disharmony and absence of copulatory dysfunctions in both partners the avoidance type of behaviour can be observed in situations with bad relations in the couple of spouses/partners, their inadequate sexual technique with resultant (in particular) sexual frustration and anorgasmia, a considerable discrepancy between sexual constitutions of the partners or their biological rhythms (for example, he a is a "morning person", while she is a "night person", or on the contrary), etc.

Directed on preservation of the former matrimonial status

1. The compensatory variant of behaviour is caused by a wish to compensate for one's sexual defect, positively manifesting oneself in other spheres and thereby gaining approval from the part of his wife or female sexual partner. Often such patients become more careful towards their spouse. They try to help her more in housekeeping, become more complaisant. In some cases the patients try to please their wife with additional earnings or closer attention and care for their children or grandchildren. Next is an example of complex behavioural changes caused by a sexual disorder, when within the family circle together with changes of behaviour for the purpose of its compensation the examined person also developed other disturbances, which were secondary to the above compensatory changes.

Patient K., 37 years old, married. He tries to compensate for his sexual defects: he does all his household shopping, cooks, does the flat (before he did all such things too, but to a considerably less extent). Trying to please his wife he pays much attention to her granddaughter born after her first marriage, though he "cannot bear" children at all. He also notes that the smell of his wife grand–daughter's faeces, as well as that of other children, produces an extremely negative effect on him.

So, along with a compensatory activation of the household–related behaviour, in this case we state a forced attention paid by the patient to the spouse's granddaughter as well as a consequence of an increase in this attention, which manifests itself by unpleasant olfactory phenomena. Besides, in the above clinical case it is also possible to observe a manifestation of generalization expressed by intolerance to the smell of any child's faeces.

2. The manipulative variant. In some cases the patients hope to improve their wife's attitude to them by sharply reduced time periods of staying in their family circle, as they believe that it may make the spouse miss them.

Directed on creation of the image of a man with a strong sexual potency

Sometimes the psychic tension, caused by existence of anxious sexual failure apprehension, reduces by means of merely nominal satisfaction of sexual demands. Thus, some patients created among their acquaintances and friends the image of a male with a high potency, who was a success

among women; they talked about their sexual victories and described their "male merits". According to our observations, such a style of behaviour is peculiar to males with hysteroid streaks in the character.

Patient Ya., 23 years old, single. Diagnosis: neurasthenia with the syndrome of anxious sexual failure expectation in the personality with character accentuation according to the hysteroid type against a background of chronic prostatitis; signs of hypoerection and premature ejaculation (ejaculatio ante portas). His friends respect and envy him as they believe that he has dated a lot of women. His authority is supported by a great number of his acquaintances with persons of the opposite sex with whom he actually has no sexual relations but his friends do not know about it. Moreover, he tells them about his sexual potencies and victories with such animation that often during this narration even he himself begins to believe in the events described by him. In fact he has sexual relations only with one woman (deep petting).

Sublimation and behavioural changes, which are phenomenologically close to it

Sublimation is a mature mechanism of psychological defence [15], by means of which instinctive energies are discharged into non–instinctive forms of behaviour [16]. This is the process by which S. Freud explains the forms of human activity, born by the force of sexual desire and having no direct connection with sexuality [17]. Sublimation results in transformation of the energy of sexual desires into the energy used for achieving socially acceptable nonsexual purposes. In his book *Vorlesungen zur Einführung in die Psychoanalyse* ("Introductory Lectures on Psycho–Analysis") S. Freud [18] notes that sexual desires participate in creating the supreme cultural, artistic and social values of the human spirit, and their contribution cannot be underestimated. He states that sublimation of sexual instincts served as the main stimulus for great achievements in the Western science and that the above sublimation is an especially marked feature if the evolution of culture. In his opinion, it is thanks to this sublimation alone that the science, art and ideology, which play a very important part in our civilized life, have managed to make an unusual development [19].

Interesting is S. Freud's opinion [20], in compliance with which a possibility of sublimation may cause a temptation to achieve its highest stages for receiving the maximum "cultural effect". He believes that such a desire for the complete sublimation is not achievable and can have sad consequences. In order to illustrate his thoughts the author tells the following funny story. Dwellers of the small town Schilda had a very strong horse, and they were very proud of this fact. Only one thing embarrassed them. Their horse ate a lot of expensive oats. Then they decided to gradually make the animal drop the habit of such an "outrage", and not only make the horse manage with a small amount of food but finally even train it to absolute abstention. At first everything was going well. The horse almost dropped the habit of eating. In the morning of the day when the animal had to work already without any oats the town dwellers found their "crafty" horse dead, but could not guess what caused its death.

It is reasonable in this context to cite S. Freud's statements [20] about results of psychoanalytical work. Characterizing each of the three outcomes, listed by him, he makes in particular the following notes. The second outcome is caused by the ability of sublimation resulting from therapy; this sublimation was blocked with displacement, which appeared early. The third outcome is caused by recognition of the right of a certain part of displaced erotic desires to be directly satisfied, since complete disregard of the "animal" nature in man deprives him of the right of happy existence and contradicts to purposes of our culture.

In this connection, interesting is the publication, which deals with discussion of the relationship between creativity and mental health [21]. This article notes that S. Freud regarded, in particular, artistic products as derivatives of sublimation, which should not be used by the fully happy personality. Nevertheless he believed that "the artist admits creative products, which originate in his subconsciousness" and at the same time does not reveal that they cause "mental pain". As this article notes, such an allowance of "Ego" control is a characteristic of the well adapted personality rather than that of the neurotic.

By means of sublimation the goal and/or object of drives are changed, whereas the discharge is not blocked but passes by artificial routes. Initial drives disappear because their energy is drawn into the cathexis of a substitute. Inhibition of the instinctive goal takes place simultaneously with the process of desexualization [22].

It is believed that the process of sublimation involves aggressive impulses rather than only sexual ones and therefore the concept of libido "desexualization" exists side by side with the special term "deaggressification", which means the process by which infantile aggressive energy loses its primitive aggressive quality [17]. Fadiman J. and Frager R. [23] reflected this situation in their definition; according to it sublimation is the process, by which the energy that was originally directed at sexual or aggressive goals is redirected at others, which are often artistic, intellectual or cultural.

Sublimation includes: a) displacement of energy from actions and objects of the primary (biological) significance to actions and objects of less instinctive significance; b) such a transformation in the quality of the emotion, which accompanies activity, when it becomes "desexualized" and "deaggressified"; c) release of the activity from the dictate of instinctive tension [16].

It should be noted that the concept of "sublimation" cannot be regarded as fully elaborated and its simple existing descriptions as sufficiently detailed. In this connection Kaplan D. M. [24] notes that sublimation was always an imperceptible (eluding) idea of the psychoanalytical thought, Laplanche J. and Pontalis J.–B. [17] pointing out the absence of definite established limits of sublimation activity. The latter authors try to clarify whether it should include the whole scope of mental activity or only some forms of intellectual creative work. Is it necessary to regard the high social assessment of sublimation–associated activity forms in this culture as the main feature of sublimation? Does sublimation include forms of "adaptive" activity (labour, leisure, etc.)? Do changes in the dynamics of desires include only goals of these desires (as S. Freud believed for a long period of time) or simultaneously their objects too? In his new lectures on introduction to psychoanalysis (*Neue Folge der Vorlesungen zur Einführung in die Psychoanalyse*, 1932) S. Freud defines sublimation as such a change of the goal and object, which takes into consideration its social assessment [in 17].

The problem of labelling different behaviuoural manifestations as sublimation with regard for their social value is also touched upon in the opposition of opinions of O. Fenichel (1945) and R. Sterba (1947) [in 22]. Thus, for example, the first of the above authors avoids admitting the viewpoint, in compliance with which sublimation–caused desexualization inevitably results in the choice of the highest and socially acceptable object, and prefers not to touch upon the value aspect of the definition. At the same time R. Sterba, like the majority of authors, discusses this aspect.

In order to explain the origin of sublimation, as well as of other mechanisms of psychological defence, it is necessary to resort to use of propositions of the psychoanalytical structural model of the human psyche [in 25]. According to the conceptions of classical psychoanalysis, the human psyche consists of three interacting structures, which produce their effect on the human behaviour: id ("the It"), ego ("the I") and super–ego ("the Over–I"). The activity of "the It" (the psyche energy storeroom, the totality of instincts) is accomplished by "the principle of pleasure", which results from discharge of the accumulated stress. An unlimited realization of impulses of "the It" could often have negative consequences for both the given individual and the whole society, since its impulses are far from being always in accord with the social context. In order to control these impulses there is "the I", that is the psyche structure based on the principle of reality. It adapts the activity of "the It" to requirements of the reality. "The Over–I" consists of "consciousness" and "the ideal I"; being the judge and censor of the activity and thoughts of "the I", "the Over–I" establishes limits of the mobility of "the I". Like "the I", "the Over–I" controls "the It", but absolutely in another way. If "the I" allows "the It" to satisfy requirements complying with the real state of things, "the Over–I" tries to subordinate "the It" to moral standards, the ideal. It is far from being always that what takes place in the reality and its requirements satisfy "the Over–I". Therefore its

desires, which do not comply with the principle of reality, can be irrational. A significant part of the energy of "the I" is directed to counteract irrational desires of "the It" and excessive demands of "the Over–I". Consequently, "the I" acts as the coordinator of requirements of "the It", demands of "the Over–I" and pressure of the outer world. **When the pressure of forces of "the It" and "the Over–I" becomes menacingly strong** (Freud A., 1936), **mechanisms of psychological defence are engaged** [in 26]. **It takes place only then when there is no possibility for satisfying instincts in accordance with demands of the society and "the Over–I". Sublimation is known to be one of defence mechanisms.**

Sublimation results in the following patterns of behaviour. Thus, it is noted that artists and ceramists may reveal their sublimated desire to spread excrements, photographers — voyeurism, dancers and actors — exhibitionism, political activity — sublimated aggression, a close friendship between adults being partially supported with sublimated homosexual and incestuous impulses [15]. Hjelle L. and Ziegler D. [19] note that, if with time masturbation causes an increasing psychic tension in a young man, the latter may sublimate his impulses into some socially approved activity such as football, hockey and other sports. Similarly, a woman with strong unrecognized sadistic inclinations may become a surgeon or a first–rate novelist. In these kinds of activity she can demonstrate her superiority over others but in such a way, which will produce a socially useful effect.

Side by side with conceptions of the strictly psychoanalytical orientation there are other opinions concerning the relationship between realization of sexual desire and other forms of activity, which, on the contrary, demonstrate a positive correlation between them. For example, Foss P. [27] notes that most of the sociological studies of sexual behaviour, conducted by this time, lack statements about interrelationship between sexual activity and activity in other spheres of life. According to his report, the results of his researches show that sexual activity and activity in studies, work, social activity, in the fields of culture, sports and other kinds of leisure do not exclude each other but, on the contrary, produce a positive effect. The opinion, which is sometimes expressed, that sex and love distract the youth from fulfilling their immediate tasks in school and at job is absolutely groundless. Eventually those young people who are happy in love and sex achieve much more than unhappy and disappointed ones.

The cited author quite definitely demonstrates his negative attitude to the psychoanalytical hypothesis of sublimation, in compliance with which one should expect that young people with a high activity in studies and work must demonstrate less sexual activity, and vice versa. But this thing does not happen. Further the author reports that results of statistical treatment of numerous tests undoubtedly confirm the common relationship between sexual and social activities. Theorists of sublimation state, as Foss P. notes, that sexuality is hostile to culture, and achievement of successes in culture and art only proves that the man has managed to restrain his vile appetencies. But his data tell us about the opposite thing. On an average, sexually active young people and those with strong happy partnership relations by no means are less active or less creative people in the field of culture.

The author proceeds with the following: in contrast to the psychoanalytical theory of sublimation we can empirically prove that in young people their general capacity for work highly correlates with developed sexual requirements. One's happy love and sex life stimulate this person's activity in other spheres of life.

Schnabl S. [28] notes a relation between sexual and social activities too. He reports that working women, especially engaged in mental work, are notable for their higher sexual responsiveness, live a more active sex life and enjoy it more than housewives do.

Similarly to Foss P. [27] speaks Weller K. [29], though his views and results of studies do not demonstrate such a marked antisublimation orientation. He notes that the higher the individual evaluates the significance of his sex life and his own sexual activity, the higher are his capacity for work and progress in studies. Sexually satisfied people are more capable for work than unsatisfied ones. But the author points out one essential detail. It turns out that the positive effect on successes

in work is produced more by the degree of one's mental satisfaction with coituses and dates rather than by their frequency. According to K. Weller's data, a high labour productivity is observed in 82% of the young people who are fully satisfied after their coitus, in 76% of those who are satisfied with some reservations, and in 71% of those who are insufficiently satisfied or not satisfied at all. This observation equally concerns representatives of both sexes. The above author also revealed one important qualitative peculiarity, which does not make possible any linear interpretation of the relation between one's progress in studies and sexual activity. Thus, the sexual activity of students, unlike that of "apprentices at enterprises and young workers", does not have any direct relationship with their successes in studies. (It is difficult to understand definitely from the text, what kind of education is meant; apparently, this is industrial training. — *G. S.* Kocharyan's note). On the other hand, sexually active people on the whole assess their studies higher and pursue science in addition to the programme more frequently than sexually less active individuals. At the same time, on the basis of his own researches the author states that whereas sexually active people are more interested in their studies, on an average they do not succeed more than less active ones. He also notes that male students from groups with moderate progress in studies have coituses most frequently. These students are followed by the best ones. The sexual activity of students with the lowest progress takes the last place. The above is true for female students too: the best and weakest ones in studies are more restrained in sex, while members of groups with moderate progress in studies have coituses most frequently.

The best students, as the author reasons, are known to face especially high demands and, of course, they want to show their highest achievements. Sometimes they, especially individuals mostly engaged in intellectual activity, reveal decreased sexual desires. Their orientation on success can result in mental stresses with negative effects on sexual requirements and feelings. But with another activity, even in case of its high intensity (as well as in physical fatigue, which results from this activity), the above phenomenon apparently occurs less frequently. Mental stresses, chiefly in intellectual activity, can affect sexual feelings.

As the author notes, the main result of the above research consists in the fact that sexual–erotic feelings and behaviour, on the one hand, and behaviour aimed at achievement of successes, on the other hand, are in the positive relationship. High achievements in studies and work, social activity and generally high capacity for work are accompanied with an increased sexual activity and an ability to feel deeply.

This position, as it seems to us, is more reasonable than that of P. Foss. His categorical negative statements as regards the psychoanalytical hypothesis of sublimation meet diametrically opposite views, set forth by Bertram B. [30] in another chapter of the same book. The author notes on the basis of her researches that partnership and professional relations can mutually balance each other. Thus, for example, insufficiently happy relations in matrimony are compensated with a stronger fancy for one's occupation and, on the contrary, a very intensive switching over to one's partner and family may result from an insufficient realization of occupational goals. A one–sided occupational orientation and diving into one's work do not contribute to sexual contacts either, but, on the contrary, result in their possible languishing.

We would like to express our viewpoint on the problem of sublimation in healthy people.

1. If we proceed from the fact that every person has some initial level of energy, than we can suppose that if he spends it for some activity to a greater extent, it results in less energy for another sphere of his activity.

2. This regularity may not be statistically observed during an examination of groups for such a simple reason that a person with a greater energy potential can be more active both in sex and work, studies, etc.

3. Sexual activity, which brings deep emotional satisfaction with intimacy of the contacts, can stimulate activity in other spheres of activity.

4. Satisfaction of sexual requirements, relief of an expressed sexual tension makes possible a more effective realization in the nonsexual sphere (the so–called homeostabilizing type of sexual motivation [31]).

5. An expressed fixation of interests on sex and a high intensity of a sex life can result in a weakened realization in other spheres.

6. The ability to sublimate in different people differs by its potential. It has differences in its levels depending upon the personality's development, i.e. in some people their sublimative manifestations may be higher by their rank than in others.

7. It seems impossible to say about simple linear correlations (positive or negative) between sexual activity and activity in other spheres because of the frequently observed action of different, sometimes very complex, combined effects of various factors.

8. It is necessary to refuse any initial ideologizing of guidelines for researches to be undertaken (acceptance or, on the contrary, rejection of the hypothesis of sublimation), since it is in the way of an objective assessment of their results.

Psychoanalysts are known to have diverse opinions about sublimation. Thus, S. Freud (1953) put it into normal defence mechanisms, which lead to formation of the mature structure of the mental apparatus, while A. Freud (1936) regarded it as a pathological mechanism [in 34].

In F. J. Bruno's opinion [32], the individual, who is not able to adequately sublimate impulses that originate from "the It", has problems with mental health and confronts with his/her parents, sexual partners, friends and law. The author supposes that one of the ways for assessing personality disorders (psychopathies), particularly the antisocial type, consists in their assessment as sublimation failures.

Sterba S. (1947) believes that pregenital tendencies in children and genital desires in adolescents and young people are sublimated much easier than genital tendencies in adults, where these tendencies become rigid in relation to the goal and can sublimate only to some degree. Furthermore, Fenichel O. (1945) even supposes that the existence of sublimation of genital sexuality in adults is hardly probable, since genitality ensures achievement of a full discharge in orgasm [in 22]. **In connection with the latter indication, nevertheless, a question arises about the possible fate of energies of "genital sexuality" in those cases when its realization is fully or partially blocked.**

As for people with sexual dysfunctions, until recently (we mean results of our researches) there was a clear and absolutely definitive position about influence of the above dysfunctions on other spheres of activity. This position was, in particular, reflected in the book *Psychohygiene of Sexual Life* by the famous Polish clinical sexologist Imieliński K. [33, p. 247]. The author notes the following:

"Mutual dependence of one's sex life and the work, done by this person, does not give rise to any doubts. In marriage, a normal sex life, which brings satisfaction, contributes to increasing the general level of the mental and physical health, improves the way the person feels and thereby has a positive impact on the work, done by this individual. Problems in a sex life produce a negative effect on both the quality of work and labour productivity. The direct negative effect manifests itself with worsening in the way the person feels, low spirits, apathy and loss of interest in work and life. The indirect negative effect results from a violation in the whole complex of the spouses' life together because of a disorganization of their sex life. The mechanism of the worsening in the quality of work here is as follows: sooner or later the problems in a sex life result in matrimonial conflicts, which worsen relations between the husband and his wife. The tension in relations between the spouses, numerous discords and scandals, and the threat of a breakup of the marriage cause a response in the form of depression, which is characterized with a steady state of low spirits, inhibited initiative and apathy, loss of interest in work and life, functional disturbances of memory, inability to concentrate one's attention on something, etc. Such a state sharply worsens the person's business abilities and sometimes even makes the work absolutely impossible".

Our special studies, whose results were first published in materials of the regional [9] and republican [10] sexological conferences and reported there (1990), have shown that in cases of a difficult sexual realization due to sexual dysfunctions, side by side with other behavioural changes the patients can develop those ones, which are caused by sublimation. A rather full presentation of these results was as early as in 1991 in our article, published on pages of an authoritative psychoneurological journal [11]. These findings were also reported by us in 1996 at the International Congress on Psychology, which was held in Montreal (Canada), and published in its materials [34]. The report was listened to with interest, and the questions asked after it demonstrated that our results were absolutely new and unexpected, since they did not conform with the well established conception of the exclusively negative influence of sexual dysfunctions on different spheres of human activity.

Before our presentation of the examples, which confirm the possibility of sublimation in people with sexual dysfunctions, we would like to express our viewpoint on criteria for regarding some or other behavioural transformations in cases of a difficult sexual realization as sublimation ones. To say frankly, it should be noted that to answer the questions, which arise in this context, is difficult. In our opinion, we cannot ignore assessment of these changes from the positions of their social significance. When behavioural transformations are examined from this viewpoint some of them may be considered as examples of energy redistribution, while others as sublimation proper. Yet it is absolutely evident that rating of something as higher than what it is compared with should be examined in its historical, culturological, motivational and situational contexts as well as with orientation for belonging of the individual to some social group or another one. Besides it is necessary to know what group is reference for this person. Therefore to define strict boundaries of sublimation is not a simple task.

As we have already noted before, when studying the behaviour of patients with different sexual disorders we revealed diverse behavioural changes in these people. The above changes had different degrees of complexity and mindfulness. Quite often their cause was not recognized at all. Here we shall describe only those of them that can be referred to sublimation and the registers, which are phenomenologically close to it; these deals with behavioural activation that could be positively assessed from social positions. The above changes were caused by difficulties in sexual realization.

Thus, our patients with sexual disorders often revealed hypertrophy of their previous hobbies or appearance of new ones. For example, one of the patients, who gave up his attempts to get greater intimacy though went on dating his female partner, began to find more time for angling then before. Another man took a great interest in tapes, bought necessary equipment and turned into the right person, who was visited by his friends and acquaintances to listen to music or re–record the concerts that they were interested in.

Besides, patients with sexual dysfunctions sometimes demonstrated intensification of their studies and social activity, “diving” into work. One of our patients before had been regarded as a rather good worker (above the average), though not notable for anything peculiar, but after development of fear of sexual failure following an unsuccessful attempt he made such a good showing in his work that was given the Gold Medal of the Exhibition of Achievements in National Economy and the Order of Labour Glory. Another patient began to work better as well as control the work of members of his team (he was a team leader) and, besides, took a second job of a carpenter, though his economic reward was not significant. Even more, he shouldered a responsible social obligation — he acted as a chief of a comrades’ court. Having developed sexual problems, one third–year student of institute, whom we examined, began to spend more time on studies and it resulted in an improvement of his progress.

We also observed one more patient, who after development of a sexual disorder began to occupy himself strenuously with upbringing of his children (despite the fact that he divorced his wife and went to live with his parents). He tried to spend much time with them: he often picked up them from the school, took them to his house for days–off, led them to different entertainments

(circus, shooting gallery, sports competitions, walks in forests, etc.). Besides, having developed sexual disorders, he began to do any additional work (in addition to his primary employment) and worked to the point of exhaustion from morning to late evening. Therefore time was left only for night sleep.

A number of patients with sexual dysfunctions revealed intensification of their cultural and scientific interests. For example, the appearance of a sexual disorder in one of our patients was followed by actualization of cultural interests. He became interested in history and reading of specialized literature: the anthology *Prometeus*, monographs about life and activities of Boris Godunov, Ivan Grozny and other historical persons. He became more interested in current politics and regularly read such journals as *Problemy Mira i Sotsializma* ("Problems of World and Socialism") and *America*, the newspaper *Za Rubezhom* ("Abroad"). He also began to pay much attention to improving his professional skills: he regularly read the American journal *Scientific American* which is published in the Russian language and contains articles on electronics (his profession is an engineer in electronics). Another patient, whom we examined, noted that following the appearance of his sexual disorder and associated difficulties in sexual realization, up to the absolute absence of sexual contacts, he began to read historical literature strenuously (about Stalin, Peter I, Robespierre, Ancient Rome, England, Spain, France). He had been interested in historical literature before that, but to a much less degree.

The activation of behaviour that could receive a positive social assessment was in some cases caused by the patients' desire to get rid of their thoughts about sexual incapacity, these thoughts disturbing them during the whole day. For this purpose they used different ways in order to distract their attention. For example, one of our patients tried to engage himself in anything not to have even a free minute. Immediately and very willingly he responded to any request about help. He tried to be overloaded with work at home: he repaired a tape–recorder, soldered, drew, read books. Also he specially suggested himself for business trips, because new surroundings and new people distracted his mind from disturbing thoughts. Another patient, who was diagnosed to have an anankastic personality disorder (psychasthenia) with anxious sexual failure expectation syndrome, willy–nilly distracted his mind from thoughts about his sexual disorder at the place of his work. But at home this way failed by itself. Therefore, in order to distract, the patient tried to do any work (domestic repairs; help to his wife, who was a school teacher, in preparing a wall newspaper).

In order to distract their mind from the above thoughts some patients begin to do different physical exercises. For example, one of our patients at home did press–ups from the floor and other exercises as well as imitated karate actions, thereby driving him to tiredness. In such a condition, as the patient stated, thoughts about his sexual incapacity disturbed him less.

Thus, our researches have revealed that patients with sexual disorders can develop behavioural changes, which should be regarded as sublimation and behaviour transformations that are phenomenologically close to it. Their results demonstrate, in particular, illegality of the one–sided approach, in accordance with which sexual disorders can result only in reduced capacity for work and confined self–actualization in any sphere of activity. As it has been shown, quite often these disturbances lead to absolutely opposite results.

Directed on elimination of the sexual disorder

The patients, whom we examined, also developed such behavioural changes, which were caused by those patients' desire to get rid of their sexual disorder. For this purpose in some cases on their own initiative they stopped drinking alcoholic beverages and smoking, started dumbbelling, jogging, going to swimming pools, having cold shower baths in the mornings, going in for autogenic training, yoga, oriental martial arts, etc. Some patients began to study books on self–perfection, phytotherapy, sexology, etc. One of our patients even tried to master a fundamental manual for physicians in sexopathology. Another patient, with the diagnosis of neurosis of (failure) expectation, bought an electro–acupuncture device, learned some biologically active points and started self–treatment, though he had not undergone any special training.

In one of our observations the man, whose sexual disorder was organized with participation of chronic prostatitis, believed that in his case long intervals between coituses produced a pathogenic effect on his sexual sphere. Therefore in order to sexually activate his spouse he began to look after his clothes in a pointed manner and often leave his home to arouse her jealousy. This patient also "frankly" talked to his mother–in–law, whom he declared that if the things went on like before he would have to divorce her daughter. But the real fact was that he did not think about any divorce at all. The above measures did result in more frequent sexual contacts for some period of time.

Sometimes in order to get rid of their sexual disorder the patients even changed their place of residence because of their search for that populated place where they could get efficient sexological help.

Asthenical

Due to their sexual disorder, in a number of cases males become embittered, irascible and sometimes lose self–control, these features manifesting themselves in the attitude to their wife and other people. Sometimes it is possible to state the coexistence of spite and obsequiousness towards the spouse. While in some cases the patient is irritable chiefly in his family, in others, on the contrary, he is irritable with his colleagues, because he tries to spare his relatives. Often the patients purposely try to avoid those situations which may cause their discharge.

Some observations revealed that a deteriorated attitude to the wife (female partner) was spread on all representatives of the female sex and pseudosubstantiated since the males did not guess about its true origin. They began to take women as vulgar and filthy creatures who expected from men only satisfaction of their sexual needs.

In one observation the patient tried to treat his wife better after a sexual disorder had appeared in him. Nevertheless his perception of other women began negative. Some time later he developed marked disgust which manifested itself by the fact that he was greatly irritated by smells given off by women except for his spouse ("... I cannot bear them, they turn my stomach ..."). He attributed it to the fact that the woman had humiliated her pride and coarsened ("women smoke, in the presence of men they talk about vulgar things and even use obscene words").

Subdepressed–depressed

In a number of cases the patients became passive and indifferent, showed little initiative, perceived all events in dim and dull colours, lost any interest in the opposite sex, studies and professional activity. Their former hobbies became indifferent for them; their interest in the life was lost. Nevertheless, in such cases (unlike in others, which occurred too) there was not any clinically manifested depression. Thus, for example, having developed sexual dysfunctions, one of our patients lost any interest in his best hobby, hunting, as well as in angling. While before he liked bee keeping (both his father and grandfather were carried away by it), at the period in question he did it without any interest. Before that, he could not stay even one hour at home at weekends, but after the appearance of the above disorders he did not long for anywhere. He could sit at a TV set half a day ("absolute apathy has come").

It was not in rare cases that unstable suicidal thoughts occurred to the patients, this fact correlating with depressive manifestations. Nevertheless we learned about their realization exclusively seldom. At the same time, owing to the unstable character of the suicidal tendencies and their little expressiveness the patients did not carry them to their logical completion and rapidly abandoned them. For example, one of our patients, who was diagnosed to suffer from neurasthenia with asthenic–depressive manifestations and anxious sexual failure expectation syndrome, during some time developed thoughts about suicide, since he regarded himself as sexually weak. One time he drank 200 g of home–distilled vodka to muster up courage and drove a motorcycle (he wanted to get smashed up). He decided to run into any oncoming transport. He drove 5 km from the neighbouring village to the one where he lived, but nobody was coming in the opposite direction. He never made such attempts any more. It is quite clear that if his decision to commit suicide had been stable he would have made more than one suicidal attempt. On the other hand, wishing to

realize his decision he could look for a busier road part (for example, in the city). Beyond all doubt, having a persistent desire to interrupt his life he could find a large number of ways to do that without such a specific stipulation.

In one case of a mixed personality disorder (mosaic psychopathy) with the hysteroid radical and anxious sexual failure expectation syndrome, after his failed attempt to have a coitus with a woman the patient made cuts on his wrists and used his blood to write on the door of the hostel room of another woman that he loved her, and then knocked at her door. He knew that she was in and would open the door to him (demonstrative suicide). He did not make any coituses with that woman (the platonic and erotic levels of interaction), and she could not explain his action.

More masked suicidal tendencies could manifest themselves in the formation of specific fatal sets. Thus, for example, when one of our patients felt extremely deep distress caused by his sexual disorder, he decided to volunteer for field forces in Afghanistan ("If I am fated to be killed I will be, if not I will survive").

Spreading of fear of failure into the situations, which are not connected with intimacy

Sometimes the patients, whom we examined, demonstrated spreading of alarm caused by intimacy into the situations, which did not have any relation to it. For example, one of our patients with the diagnosis of failure expectation neurosis noted that some time before tachycardia and loss of ability to think logically began to appear in him during speeches before his collective or before an important talk rather than in intimacy only. Another patient, who was diagnosed to have a sexual disorder caused by the hypersthenic form of neurasthenia (a significant part in whose development was played by a sexual disorder), anxious failure expectation syndrome and chronic prostatitis, complained that, besides his anxious sexual failure expectation, every time when he was training at the gym the act of shaking hands aroused in him the fear that his competitor was stronger than he was, though in the overwhelming majority of cases it was not so. That "paralyzed" him and he lost the fight in its initial stage.

Loss of initiative in establishment of relations with women, specific restrictions at the choice of a female partner

Sometimes the patients with anxious expectation of a failure in intimacy due to a sexual disorder changed their approach to the choice of their sexual partner. Often women chose them themselves. At times the patients did not reject the initiative even of those women, whom they did not like much or to whom they were absolutely indifferent, and established rather stable relations with them. This fact is quite easy to be explained, since in such cases their responsibility for the quality of the sexual intimacy was reduced and the males did not feel then such an expressed psychic tension; it improved the quality of the sexual intercourse or, moreover, even made it possible. In those cases the patients were not afraid to part with their female partner, if they did not satisfy her in the sexual aspect, because they did not value that relation. Sometimes it was a contact with such women who were significantly inferior to them in intellectual development rather than did not impress the patients only by their outward appearance. The fear that he would disgrace himself in attempts to have sexual relations with other women, whom the patient liked, produced a stabilizing effect on the existing relations which were maintained mostly on the female partner's initiative.

Making their acquaintance of women, the patients were afraid to establish sexual relations with those females who, as they thought, had great sexual needs and therefore could set such requirements which were high or even usual for a sexually healthy male. For this reason with much attention those patients assessed any statements, made by their supposed female partners concerning their previous sexual experience, and their behaviour. For instance, in the case if some woman told one of the patients, whom we observed, about "an impotent male" who was unable to do anything with her, the patient broke that woman at once, as he made a prognosis of her attitude towards his "failure".

Behavioural transformations caused by dynamic shifts of character's traits

Some part of the patients, whom we observed, also developed reticence, reserve, heightened jealousy, pliability, taciturnity, pensiveness, heightened suspiciousness and impressionability, which were absent before the development of sexual disorders and neutralized in case of elimination of the copulatory impairments. Such dynamic characterological shifts modified their behaviour. We also registered a change in the attitude to other people in the positive direction; this change appeared after the development of a sexual disorder. Thus, for example, one of our patients with failure expectation neurosis began to treat other people better. While before he had divided them only in bad and good, after the above moment he found something good in any bad person. He became more warm–hearted and compassionate to those people, who suffered from something.

It should be noted that very often the patterns of behaviour, which we have described above, were not isolated but existed in different combinations. Therefore we can state that each of these patterns can function as the radical in a complex behaviour constellation. For example, the depressive radical was very often observed in combination with the asthenic one. Thus, after the development of his sexual disorder one of the patients whom we mentioned during our description of the subdepressive–depressive type of behaviour also became irritable and hot–tempered, this feature manifesting itself both in home environment and at his job.

Often the loss of interest in life (subdepression) caused by a sexual disorder can be combined with behavioural activation. Thus, for example, one of the patients whom we examined began to spend more time at his job (he used to remain after the end of his shift); it resulted in improvement of his work showing. Consequently, his earnings increased and he was encouraged several times. He began to spend more time for angling. But at the same time he became more passive and indifferent.

Quite often it is possible to reveal diverse behavioural changes, which undergo significant dynamics depending upon the situation and the patient's condition.

Patient P., 25 years old, single. Two years before, next day after one of his unsuccessful attempts he found a note on the door of the flat where his acquaintance lived; she wrote that he should not come there any more because she needed a real male. Before that day his response to failures was rather composed, but after that his mood rapidly became sullen and anxious sexual failure expectation syndrome developed. He hardly made himself go out to work, after it he immediately went home and went to bed. All the time he kept thinking about what had happened. He wanted to leave his job and go to his parents, who lived in the country, in order not to see anybody there in such a remote place, as it was all the same, nobody needed him. Making a prognosis of his country life he said that he "might become an inveterate drunkard". At the same time he managed to be distracted from dismal thoughts at the place of his work. Even despite the fact that he liked his profession of a test driver very much, he handed in an application for dismissal. But since there was a very tense situation with personnel he was persuaded not to leave the job. Talking about that period the patient remembered that after the end of his shift he watched with envy and bitterness how the boys were met by their girls. In that period he became a more zealous worker devoting all the time to his job responsibilities; he used any pretence to stay there as long as possible. On his own initiative he often stayed to work at night shifts. He subscribed to a library and became an avid reader (before that he had read very seldom). During one month he read 6–8 books. Within 1–2 months after reading the above note he avoided people and tried to have as little contacts with them as it was only possible. Then, on the contrary, after the end of his shift he began to join with companies of young men who drank alcoholic beverages very much. While before he had used strong drinks in small doses only on Sundays and holidays, then it became almost every day that he drank a fair amount of alcohol. Once he drank so much that even wallowed in the street and was delivered to a sobering station.

The above fragment of a case history shows that the negative evaluation of the young man's sexual merits by his female partner against a neurotic depressive background resulted in different behaviour changes (preoccupation with work, alcoholophilia, a sudden passion for belletristic

literature), which should be interpreted as manifestations of the mechanism of psychological shift–type defence. Besides, the patient developed a pathological motivation to migrate.

Side by side with the ten patterns of the changed behaviour resulting from sexual dysfunctions that we have isolated and presented above, its hyposexual and hypersexual patterns should be isolated too.

The hyposexual behaviour pattern

Though the reduction of libido, which underlies the characterized pattern of behaviour, can be observed in various forms of sexual disorders, this behavioural pattern is most vividly represented in hypogonadism, depressive and apathoabulic syndromes, lesion of the diencephalon ("diencephalic impotence") as well as in general sexological practice in cases of a weak sexual constitution and sexual involution. Let us dwell on the behavioural characteristics of the two latter kinds of sexual disorders.

When they see their patients, clinical sexologists may often diagnose such sexual dysfunctions, which are somehow connected with a weak sexual constitution, the latter being caused by a pubertal disorder (a pubertal delay or disharmony). To our mind, in such cases where medical advice is sought by males who left the age area of their puberty period long ago, the diagnosis should contain the terms that point to the presence of a weak sexual constitution. In those cases when the constitutional factor is the chief one for the development of sexual dysfunctions, it is reasonable to say about the constitutional form of the disorder; but when a weak sexual constitution predisposes the appearance of the above dysfunctions, we should use the word combination "against a background of a weak sexual constitution". Our suggestion becomes understandable, if the following analogy is made. An adult male, who seeks sexological advice because of infertility, reveals absence of spermatozoa in his sperm. It turns out that in childhood he was ill with epidemic parotitis (mumps), and the pathological process involved his testicles (testes); this is confirmed by an objective examination. Quite naturally, the physician will not make now the diagnosis of epidemic parotitis in this patient, but the diagnosis will reflect those consequences, which that disease resulted in. Such a diagnosis as "constitutional/constitutional–genetic" disorder is reflected in sexological classifications by Sviadoshch A. M. [35] and Krishtal V. V. [36, 37]. It concerns both men and women.

The constitutional form of a sexual disorder can result from an influence of genetic factors, harmful effects during the antenatal, natal and postnatal periods, in the process of the organism's further growth and development before or during the puberty period (infections, intoxications, brain injuries, undernourishment, protracted chronic diseases, etc.).

It is important to note that the first place among the causes, which lead to a delay of puberty, is given to constitutional peculiarities in the reproductive system maturation. In those families, where the parents and elder relatives develop their secondary sexual structures, ejaculation and menarche late, the children, as a rule, have a delay in their sexual development [38]. To our mind, in such cases we can say about a particular "constitutional–genetic" variant of the constitutional form of a sexual disorder.

The factors, which cause a delay in the sexual development, are initial causes for the formation of a weak sexual constitution.

The constitutional form of sexual dysfunctions does not include cases of hypogonadism, since the above form is characterized by some polyglandular (caused by involvement of a number of endocrine glands) deficiency. It is possible to exclude hypogonadism due to the presence of pregnancies in case histories of sexual female partners of the examined male, the normal or subcritical size of his testes, his fertile ejaculate. That is, in this case the viability of procreative (connected with the continuation of mankind) abilities is revealed regardless of the degree of disturbance of recreative (sexual functions) manifestations [39].

Consequently, when such people are examined by the endocrinologist, the latter does not find in them any pathology in his field, i.e. from his viewpoint these patients are healthy people.

When he examined males with a weak sexual constitution caused by a delay of puberty, Livschitz O. Z. [40] paid much attention to studying the "soil", namely the neurohumoral deficiency, which plays a significant part in an insufficient supply of sexual functions. The author gives the following sexual–behavioural characteristic of the people, who had a "delayed type" of pubescence. Their first sexual interests appeared with a considerable delay versus other people of the same age and were mostly of the imitative character. The period of juvenile hypersexuality with its inherent erotic fantasies, pollutions and spontaneous erections in the majority of patients was not revealed at all. A wish to have children or a need not to differ from other people served as the basic incentives for starting a sex life. Only a quarter of married men made the acquaintance of their future wife by themselves, with whom furthermore they studied or worked together. The rest made the acquaintance of their spouses on their relatives or friends' initiative. In the majority of cases the patients sought medical advice for their sexual disorders on the initiative of their wives or relatives. Such disorders were of little importance for them and were not a strong psychotraumatic factor. In this connection a suggestion is made that some mental features in the above patients and mainly the types of their emotional responses to sexual pathology depend to a certain extent upon that somatobiological basis, on which they formed. This suggestion is based on the comparison of responses in the above people and males, who revealed signs of an accelerated pubescence and whose responses to their sexual dysfunctions were sufficiently manifested.

Libido in people with a delayed pubescence is affected initially. This dysfunction does not develop with time as it takes place in many other forms of sexual disorders. The patients may not regard their libido reduced because simply they do not have anything to compare it with. Therefore it is clear that a libido disorder, which is key and participates in the organization of other (derivative) symptoms, takes the last place among sexological complaints (as it is shown by the data, presented by Vasilchenko G. S. [39]). In a number of cases some improvement, manifested by a reduction in the duration of coitus resulting from a regular sexual activity (*ejaculatio tarda* is replaced with the normal duration of coitus), is assessed by the patient as a disorder, which may serve as a reason for seeking sexological advice [39]. Often, not realizing the constitutional nature of sexual dysfunctions, the characterized patients attribute them to some external circumstances. Characterizing the strength of libido and its manifestations, we should emphasize that these people reveal reduction of their sexual needs and sexual activity at all age stages. It is clear that this fact is caused by a weak sexual desire. Vasilchenko G. S. [39] even notes that in 1/10 of the patients, whom he examined, by the moment when they sought sexological advice their libido never awoke, though the term for it had expired long before. In some of the patients their sexual desire even had not developed up to the erotic level. In those cases where this level is after all reached, at the first stages of the marriage the above circumstance can play some positive part. The latter is caused by the fact that erotic libido manifests itself in such traits as tenderness and affectionateness, and leads to accentuation on caresses and kisses of the preliminary period. The above features of males ensure harmonious formation of sexuality in their wives earlier and more reliably than in those cases, where husbands have a stronger sexual constitution. More prolonged caresses, mostly addressed to extragenital areas, and absence of the incoercible sexual pressure, which often manifests itself in underestimation of the importance of the preliminary period and in the desire to pass to the main period of the coitus without any delays, are welcomed by women because they are more satisfying for specific features of female sexuality. But later this larger, if compared with males having higher constitutional parameters, ability to arouse their drowsing sexuality in a larger percentage of women in some cases eventually gets such males themselves into trouble. This is caused by the fact that after her sexuality has awakened the wife sometimes forms such a high sexual need that her husband fails to satisfy [39].

Hyposexuality is observed in sexual involution too. With age, elderly males develop a gradual natural weakening of sexual functions. This weakening results from development of reduction of the pluriglandular provision of the above functions as well as from influence of a number of other

factors, where a great part is played by atherosclerotic lesions of the vessels that participate in the provision of erection.

In order to characterize the state of organism in elderly men different terms are used; for example, these are climax, andropause and syndrome of partial androgen insufficiency.

Sexual disorders, caused by ageing (syndrome of sexual involution), clinically manifest in males at different ages. According to the data of the All–Union Centre for Problems of Sexopathology (Moscow), the age range of such patients, who sought sexological advice, was 36–72 (mean 50.3 ± 0.32) years. The age, when they noted appearance of the first signs and symptoms of their sexual disorder, was 28–69 years. Vasilchenko G. S. [39] notes that the syndrome of sexual involution manifests itself most commonly by a reduction of libido. This should be regarded as the key symptom. He also emphasizes the fact that during the initial phases the above reduced libido significantly prevails over erectile disturbances, which take the last place by their frequency. He accentuates the following aspect: those people with sexual involution, who got into the field of view of the sexopathologist, had retardation of their puberty period.

On this basis, a false conception may form that the syndrome of sexual involution never develops in people, who do not have any constitutional deficiency caused by some delay or retardation of the puberty period. Yet Vasilchenko G. S. [39, p. 247] notes the following: “In the absence of any sexual deficiency males do not come to the sexopathologist, because by the time of the involutional reduction of sexual needs their value orientations shift towards other life manifestations”.

Sexual involution phenomena beyond all doubt develop naturally in elderly males even without any constitutional (we mean sexual constitution) deficit. Only it occurs at an older age. Their adequate perception of the natural character of the changes, which take place, on the basis of understanding of the inevitability and naturalness of their gradual age–related sexual decline may underlie the fact that such men simply do not seek sexological advice.

When it is the matter of pathological climax, which can develop in males at a much younger age, even then they seek sexological advice extremely seldom. In such cases sexual disorders are revealed only during an active detailed questioning of such patients. Vartapetov V. A. and Demchenko A. N. [41] explain this phenomenon by predominance of worse general symptoms in these patients with a resultant movement of complaints of the sexological character to the background. As these authors note, the above fact can be helpful in differential diagnosis. If sexual insufficiency is the main, or sometimes even the only, complaint in some patients, as a rule they do not belong to the category of people, who suffer from pathological climax.

It should be noted that the hyposexual pattern of behaviour per se in sexual involution can embrace only the cases, where this involution is not accompanied with any expressed negative emotional responses, including those ones that reach the level of neurotic disturbances.

The hypersexual behaviour pattern

This pattern manifests itself by sexual activation, which can be observed in both masturbation and sexual interactions with other people. Hypersexuality is known to occur in lesions of the hypothalamus and limbic system of brain (resulting from neuroinfections, injuries, vascular lesions, neoplasms), hyperfunction of the adrenal cortex of tumour genesis (androsteroma), hormonally active tumours of the ovary, climacteric period, manic and hypomanic syndromes with affective dysthymia and circular form of schizophrenia, treatment with large doses of androgens, after bad psychic traumas. Also, there are other causes, which underlie hypersexuality.

Behaviuourally, hypersexuality manifests itself with an increased yearning for sexual activity (through masturbation or with other people), its intensification, “loss” of modesty, sexual pliability and compliance, need to talk on sexual subjects as well as listen and tell obscene jokes, easy striking up of acquaintances with potential sexual objects, “loss” of the moral sense, numerous promiscuous extramarital affairs, difficulties in achievement of sexual satisfaction, open demonstration of sexual (masturbatory and in a couple) activity, group sex, incapacity for

productive activity in other fields owing to a strong sexual tension, the latter resulting in an expressed fixation on the sexual sphere. Hypersexuality leads to conflicts and quarrels in matrimony/partnership, because in this situation the second member of the dyad does not correspond to extremely inflated sexual requirements of the patient and cannot satisfy them. This is fertile soil for the appearance of deviant/paraphilic activity.

As it follows from the above characteristics of the hyposexual and hypersexual behaviour patterns, their inherent behavioural features are centered mostly in the sexual sphere.

Characterizing behavioural transformations, caused by sexual dysfunctions, we would like to share our following findings. In some cases of anorgasmia in women we observed activation of their sexual initiative, which based not on an increase of her sexual attraction but on a wish to find such a man who would be able to satisfy her sexually. Moreover, the appearance of every new challenger who wished to become their sex partner heightened those women's self–rating, as it demonstrated that they were the source of an undiminishing sexual desire. Thus, the women somehow compensated the feeling of their own impairment caused by the presence of sexual problems in them. This circumstance was an additional stimulus for them to establish still new and new relations.

On the basis of findings of our studies the conclusion was made that the area of disorders in patients with sexual dysfunctions could go far beyond the scope of copulatory "failures" and behavioural changes associated with intimacy [14] and have pronounced social, rather than only personal, consequences.

When a programme of the adequate psychotherapeutic correction for patients of sexological type is drawn, one should take into consideration a possible appearance of behavioural changes (caused by sexual dysfunctions) outside intimacy.

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