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Syndrome of anxious expectation of sexual failure (fear of sexual failure) in males: some aspects of its formation

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The objective: **Study of some aspects in the formation of syndrome of anxious expectation of sexual failure (SAESF), chiefly of the neurotic genesis, were studied in 220 males.**
Materials and methods**. Three variants of its formation were separated (premanifest, manifest, postmanifest: acute-subacute and chronic). This was determined by period of their occurrence in relation to manifestation of sexual disorders. Also twenty groups of psychological traumatic factors, which took part in the development of the syndrome were identified: normal physiological discharge, pains and pathological changes in the genitals, violation of spontaneous sexual indices, violation of adequate sexual manifestations in erotic contacts, copulatory (physiological and pathological) disorders, homosexual episode, reproaches and behaviour of the female partner, unfaithfulness of the wife, fear of dissatisfaction for the wife, fear of appearing disabled before the eyes of an experienced female partner, divulgence of information about sexual disability, onanophobia, fear of consequences of sexual abstinence, iatrogenia, reading of medical literature and acquaintance with medical documents, information about pathogenic influence of microwave frequencies, information about negative effects of anabolic hormones, apprehension of a possible deterioration of sexual functions in prospect, activation of recollections of previous sexual failures, confidence in one's own unattractiveness.**
Results**. The degree of participation of these factors in the formation of the above SAESF variants as well as proximate causes of sexual «malfunctions» with the resultant postmanifest development of the studied syndrome were analysed.**
Conclusion**. The conclusion is drawn that the obtained results will make it possible to solve problems of SAESF prevention more effectively.**
Keywords: *syndrome of anxious sexual failure expectation, formation, males.*

Синдром тривожного очікування сексуальної невдачі у чоловіків: деякі аспекти його формування

Г.С. Кочарян

Мета дослідження: вивчення деяких аспектів формування синдрому тривожного очікування сексуальної невдачі (СТОСН) переважно невротичного генезу у 220 чоловіків.
Матеріали та методи. Виділено три варіанти його формування, які визначалися по відношенню до періоду маніфестації сексуальних розладів (доманіфестний, маніфестний, постманіфестний: гострий-підгострий і хронічний), і 20 груп психотравмуючих чинників, які брали участь в його розвитку: нормальні фізіологічні виділення, біль і патологічні зміни в статевих органах, порушення спонтанних сексуальних показників, порушення адекватних сексуальних проявів при еротичних контактах, копулятивні порушення (фізіологічні і патологічні), гомосексуальний епізод, докори і поведінка партнерки, зрада дружини, боязнь не задовольнити дружину, побоювання постати неспроможним в очах досвідченої партнерки, розголошення відомостей про сексуальну неспроможність, онанофобія, боязнь наслідків сексуальної абстиненції, ятрогенія, читання медичної літератури та ознайомлення з медичною документацією, інформація про патогенний вплив СВЧ, відомості про негативну дію анаболічних гормонів, побоювання щодо погіршення сексуальних функцій у перспективі, активізація спогадів про минулі сексуальні невдачі, впевненість у власній непривабливості.
Результати. Проаналізовано ступінь участі цих факторів у формуванні названих варіантів СТОСН, розглянуто безпосередні причини сексуальних «збоїв», що призвели до постманіфестного розвитку цього синдрому.
Заключення. Зроблено висновок, що отримані результати дозволять більш ефективно вирішувати питання профілактики СТОСН.
Ключові слова: *синдром тривожного очікування сексуальної невдачі, формування, чоловіки.*

Синдром тревожного ожидания сексуальной неудачи у мужчин: некоторые аспекты его формирования

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Цель исследования: изучение некоторых аспектов формирования синдрома тревожного ожидания сексуальной неудачи (СТОСН) преимущественно невротического генеза у 220 мужчин.
Материалы и методы. Выделено три варианта его формирования, что определялось периодом их возникновения по отношению к манифестации сексуальных расстройств (доманифестный, манифестный, постманифестный: острый-подострый и хронический), и 20 групп психотравмирующих факторов, участвовавших в его развитии: нормальные физиологические выделения, боль и патологические изменения в половых органах, нарушение спонтанных сексуальных показателей, нарушение адекватных сексуальных проявлений при эротических контактах, копулятивные нарушения (физиологические и патологические), гомосексуальный эпизод, упреки и поведение партнерши, измены жены, боязнь не удовлетворить супругу, опасение предстать несостоятельным в глазах опытной партнерши, разглашение сведений о сексуальной несостоятельности, онанофобия, боязнь последствий сексуальной абстиненции, ятрогения, чтение медицинской литературы и ознакомление с медицинской документацией, информация о патогенном влиянии СВЧ, сведения о негативном действии анаболических гормонов, опасение ухудшения сексуальных функций в перспективе, активизация воспоминаний о прошлых сексуальных неудачах, уверенность в собственной непривлекательности.
Результаты. Проанализирована степень участия этих факторов в формирования названных вариантов СТОСН, рассмотрены непосредственные причины сексуальных «сбоев», приведших к постманифестному развитию данного синдрома.
Заключение. Сделан вывод, что полученные результаты позволят более эффективно решать вопросы профилактики СТОСН.
Ключевые слова: *синдром тревожного ожидания сексуальной неудачи, формирование, мужчины.*

Different kinds of mental disorders often initially underlie sexual disorders and rather frequently complicate their course. Only pivotal involvement of the mental component of the copulatory cycle is diagnosed in 50.8% of examined males, who take sexological advice [2]. At the same time different diseases, which characterize involvement of the above component, very often reveal anxious sexual failure expectation syndrome (SAESF). This syndrome is also observed in personality disorders (psychopathies) [3] and endogenous mental diseases [5, 6, 7] rather than only in sexual disorders initially of the neurotic nature [1]. Besides, apprehension of a failure rather often complicates the course of many sexual disorders of the somatic origin with the final formation of the persistent SAESF; the latter acts as the functional mechanism that aggravates the course of the sexual disorder. Thus, this syndrome is very common. As a matter of fact, SAESF can be called the most universal sexopathological syndrome in males, because it occurs in various kinds of sexual disorders [4]. The above fact determines the importance of the comprehensive study of SAESF, including its formation. The study of this formation makes it possible both to understand its mechanisms and, what is particularly important, to outline a set of prophylactic measures, which prevent appearance of the above pathology.

MATERIALS AND METHODS

In order to study some aspects in the formation of SAESF we carried on special investigations (inquiry) of 220 patients, who were examined by us and in whom neuroses were mainly diagnosed. All the patients were divided into three groups depending upon the time of appearance of the studied syndrome in them; this was determined with respect to the period of manifestation of sexual disorders.

The first group (*premanifest formation*) was composed of the patients (27 cases; 12.3±1.1%), in whom SAESF developed before the appearance of these disorders. The second group included the males (5 cases; 2.3±1.0%), in whom the appearance of the above syndrome coincided in the chronological aspect with the manifestation of sexual disorders (*manifest formation*). When characterizing this group, we should note that during some years the first sexual contacts of its patients with their new female partners were without fail characterized by anxious expectation of a failure and always accompanied with sexual malfunctions, while subsequent cotuses with the same women passed, as a rule, without any defects. But last time such a spontaneous normalization did not occur, this fact making the men take medical advice.

The third group consisted of the patients (188 cases; 85.5±2.4%), in whom SAESF developed after the manifestation of sexual disorders (*postmanifest formation*). The latter group, in its turn, was divided into two subgroups. The first one contained the patients (124 cases; 66.0 ± 3.5%), in whom their manifestation of sexual disorders was followed by the *acute* or *subacute* development (after one or several unsuccessful attempts) of SAESF. The second subgroup was composed of the patients (64 cases; 34.0±3.5%), in whom the studied syndrome developed *gradually* (one month – a few years) after sexual disorders were revealed.

It should be noted that it was far from being always that the subacute, and sometimes even acute, development could be easily distinguished from the gradual development, because at times a rather long period passed from the first unsuccessful attempts to subsequent ones. In such cases analysis of the state of patients during the period, which separated the first failures from subsequent ones, was effective. Table 1 demonstrates distribution of the patients into the above groups and subgroups, which characterize the appearance of SAESF.

RESULTS

A significant number of factors, which produced psychological traumatic effects and participated in the development of SAESF, were found out. These were united into 20 groups: “normal physiological discharge”, “pains and pathological changes in the genitals”, “violation of spontaneous sexual indices”, “violation of adequate sexual manifestations in erotic contacts”, “physiological and pathological copulatory disorders in sexual contacts”, “homosexual episode”, “reproaches and behaviour of the female partner”, “unfaithfulness of the wife”, “fear of sexual dissatisfaction for the wife”, “fear of appearing disabled before the eyes of an experienced female partner”, “divulgence of information about sexual disability”.

Also other factors were revealed, such as onanophobia, fear of consequences of sexual abstinence, iatrogenia, reading of medical literature and acquaintance with medical documents, information about pathogenic influence of microwave frequencies, information about negative effects of anabolic hormones, apprehension of a possible deterioration of sexual functions in prospect, activation of recollections of previous sexual failures, confidence in one’s own unattractiveness. After exclusion of 5 cases (2.3±1.0%), who comprised the group of patients in which the manifestation of their disorder every time had a strikingly systematic coincidence with a début of sexual contacts with a new female partner, all above factors were investigated in the remaining 215 men (97.7±1.0%). As for the 5 patients (2.3±1.0%) with the manifest variant of SAESF formation, excluded from this investigation, it should be noted that, as a rule, no psychological traumatic factors in the appearance of anxious failure expectation could be revealed. Only in one of the five cases the patient regarded the normal duration of his first coitus as insufficient. Two of the remaining four patients revealed accentuation of personality traits of the anxious-hypochondriac type, and one case had a mixed personality disorder. Only one patient was a person with the harmonious personality make-up.

Taking into account of the different factors, which were mentioned above and participated in the formation of the studied syndrome in the group of patients, who had SAESF even before the manifestation of their sexual disorders (27 cases; 12.3±2.2%), showed that physiological discharge (smegma) served as the psychological traumatic factor in 1 person (3.7±3.6%), pains and pathological changes in the genitals in 5 (18.5±7.5%), violation of adequate sexual manifestations in erotic contacts in 2

Table 1

Formation of anxious sexual failure expectation syndrome in the chronological aspect

Chronological variants of SAESF	Examined patients	
	Absolute number	P±Sp
Premanifest	27	12.3±2.2
Manifest	5	2.3±1.0
Postmanifest a) acute and subacute development b) gradual development	188 124 64	85.5±2.4 66.0±3.5 34.0±3.5
Total	220	100

(7.4±5.0%), homosexual episode in 1 (3.7±3.6%), reproaches and behaviour of the female partner in 2 (7.4±5.0%), unfaithfulness of the wife in 1 (3.7±3.6%), fear of sexual dissatisfaction for the wife in 1 (3.7±3.6%), fear of appearing disabled before the eyes of a sexually experienced female partner in 1 (3.7±3.6%), onanophobia in 6 (22.2±8.0%), fear of consequences of sexual abstinence in 3 (11.1±6.0%), iatrogenia in 2 (7.4±5.0%), reading of medical literature and acquaintance with medical documents in 2 (7.4±5.0%), information about pathogenic influence of microwave frequencies in 1 (3.7±3.6%), apprehension of a possible deterioration of sexual functions in prospect in 1 (3.7±3.6%), activation of recollections of previous sexual failures in 1 (3.7±3.6%), confidence in one's own unattractiveness in 1 (3.7±3.6%). Though no reliable differences in the rate of the psychological traumatic effect of the above factors could be revealed, nevertheless attention is attracted by the fact that the first place in their line is taken by ideas about pathogenic influence of masturbation (6 cases; 22.2±8.0%) and the second one by worry caused by the presence of pains and pathological changes in the genitals (5 cases; 18.5±7.5%).

In the group of patients with the postmanifest formation of SAESF, which consisted of 188 cases (85.5±2.4%), the rate of psychological traumatic effects of different factors was as follows. Pains and pathological changes in the genitals resulted in the development of this syndrome in 1 case (0.5±0.5%), violation of spontaneous sexual indices in 2 (1.1±0.8%), copulatory (physiological and pathological) disorders in sexual contacts in 146 (77.7±3.0%), reproaches and behaviour of the female partner in 47 (25.0±3.2%), unfaithfulness of the wife in 2 (1.1±0.8%), fear of dissatisfaction for the wife in 1 (0.5±0.5%), divulgence of information about sexual disability in 1 (0.5±0.5%), fear of masturbation consequences unfavourable for potency in 1 (0.5±0.5%), iatrogenia in 2 (1.1±0.8%), reading of medical literature and acquaintance with medical documents in 1 (0.5±0.5%), information about negative effects of anabolic steroid hormones in 1 (0.5±0.5%).

Analysis shows that sexual (physiological and pathological) disorders in coituses (77.7±3.0%) as well as reproaches and behaviour of the female partner (25.0±3.2%) were observed in this group reliably more frequently versus other psychological traumatic factors. These effects prevailed over all others so significantly that there is no need to give special frequency comparisons in each particular case. At the same time it is reasonable to compare the pathogenic influence of these two main psychological traumatic factors. This comparison demonstrates that sexual (physiological and pathological) disorders took part in the formation of SAESF much more frequently than reproaches and behaviour of the female partner (respectively, 77.7±3.0% and 25.0±3.2%; $p<0.001$).

Since before the group of patients with the postmanifest development of SAESF was divided by us into two subgroups with its acute and subacute (124 cases; 66.0±3.5%) as well as gradual (64 cases; 34.0±3.5%) formation, it is reasonable to inform about the rate of influence of those different factors, which participated in the formation of the studied syndrome separately for these two subgroups.

Thus, in the acute and subacute development of SAESF pains and pathological changes in the genitals were registered as the psychological traumatic factor in 1 case (0.8±0.8%), violation of spontaneous sexual indices in 1 (0.8±0.8%), copulatory (physiological and pathological) disorders in 101 (81.5±3.5%), reproaches and behaviour of the female partner in 24 (19.4±3.6%), divulgence of information about sexual disability in 1 (0.8±0.8%), iatrogenic effects in 2 (1.6±1.1%), information about negative effects of anabolic steroids in 1 (0.8±0.8%). In this subgroup, like in the whole group with the postmanifest formation of SAESF, such psychological traumatic effects as copulatory (physiological and pathological) disorders as well as reproaches and behaviour of the female partner reliably prevailed over all other above factors. Besides, like in the group as a whole, sexual "malfunctions" in coituses acted as the psychological traumatic factors reliably more frequently than reproaches and behaviour of the female partner (respectively, 81.0±3.5% and 19.4±3.6%; $p<0.001$).

In the subgroup with the gradual development of SAESF (64 cases) the ratio of the above factors, which took part in its formation, was as follows. Violation of spontaneous sexual indices was registered as the psychological traumatic effect in 1 case (1.6±1.6%), copulatory (physiological and pathological) disorders in 45 (70.3±5.7%), reproaches and behaviour of the female partner in 23 (35.9±6.0%), unfaithfulness of the wife in 2 (3.1±2.2%), fear of dissatisfaction for the wife in 1 (1.6±1.6%), onanophobia in 1 (1.6±1.6%), reading of medical literature and acquaintance with medical documents in 1 (1.6±1.6%). In this subgroup, like in the previous one, a reliable prevalence of two factors (sexual "malfunctions" in coituses and reproaches and behaviour of the female partner) over all others was observed. Like in the previous subgroup, copulatory (physiological and pathological) disorders produced reliably prevailing effects on the development of SAESF versus reproaches and behaviour of the female partner (respectively, 70.3±5.7% and 35.9±6.0%; $p<0.001$). The rate of revealing of all the above factors, which participate in the formation of different chronological variants of SAESF, is shown in Table 2.

It should be noted that one of the above psychological traumatic factors was found out during the premanifest development of the studied syndrome (all in all 27 observations) in 25 cases (92.6±5.0%), two in 1 (3.7±3.6%), three in 1 (3.7±3.6%). But in the postmanifest development of SAESF (all in all 188 observations) one factor was revealed in 171 cases (91.0±2.1%), two in 17 (9.0±2.1%). In the acute and subacute postmanifest development of SAESF (all in all 124 observations) one of the above factors was found in 117 cases (94.4±2.1%), while during the gradual development (all in all 64 observations) in 54 (84.4±4.5%), this fact demonstrating reliable ($p<0.05$) differences. Two factors, which participated in the formation of SAESF, were revealed during the gradual as well as acute and subacute development, respectively, in 10 (15.6±4.5%) and 7 (5.6±2.1%) cases, thereby also showing significant ($p<0.05$) differences.

In order to deepen our understanding of the formation of SAESF we also analysed proximate causes of sexual "malfunctions", which resulted in the postmanifest development of the studied syndrome.

We received the following results. In the subgroup with the acute and subacute development of SAESF (124 observations) the order of the causes of "malfunctions" according to their rate decrease was as follows. True sexual disorders were revealed in 23 cases (18.5±3.5%), sexual abstinence and dysrrhythmia in 23 (18.5±3.5%), use of alcohol in 17 (13.7±3.1%), different degrees of an increase of the preliminary period in 15 (12.1±2.9%), unfavourable conditions for intimacy with inclusion of different external interference in 10 (8.1±2.5%), excitement, depression, etc., in 8 (6.5±2.2%), negative perception of physical and mental qualities and characteristics of the female partner in 8 (6.5±2.2%), fatigue, general asthenization in 7 (5.6±2.1%), thoughts about a possible failure in 3 (2.4±1.4%), fixation of attention on penile tension in 3 (2.4±1.4%), violation of continuity during intimacy (putting on a condom, etc.) in 2 (1.6±1.1%).

Each such factor with the resultant sexual "malfunction" as idealization of the woman, sense of guilt with respect to her, absence of the wish, change in the sex position, pain in the testis, disbelief of the man that such a beautiful woman at last belongs to him, distraction of attention, exceeding of the optimum individual sex rhythm and iatrogenia occurred in 1 patient (0.8±0.8%). The

Table 2

Frequency characteristic of psychological traumatic factors, which participate in the formation of different chronological variants of SASFE

Factors, which take part in the formationof SAESF	Chronological variants of SAESF							
	Premanifest (27 cases)		Postmanifest					
			Total (188 cases)		Acute and subacute development (124 cases)		Gradual development (64 cases)	
	Abs. number of cases	P±S_p	Abs. number of cases	P±S_p	Abs. number of cases	P±S_p	Abs. number of cases	P±S_p
Normal physiological discharge	1	3.7±3.6	–	–	–	–	–	–
Pains and pathological changes in the genitals	5	18.5±7.5	1	0.5±0.5	1	0.8±0.8	–	–
Violation of spontaneous sexual indices	–	–	2	1.1±0.8	1	0.8±0.8	1	1.6±1.6
Violation of adequate sexual manifestations in erotic contacts	2	7.4±5.0	–	–	–	–	–	–
Copulatory (physiological and pathological) disorders	–	–	146	77.7±3.0	101	81.5±3.5	45	70.3±5.7
Homosexual episode	1	3.7±3.6	–	–	–	–	–	–
Reproaches and behaviour of the female partner	2	7.4±5.0	47	25.0±3.2	24	19.4±3.6	23	35.9±6.0
Unfaithfulness of the wife	1	3.7±3.6	2	1.1±0.8	–	–	2	3.1±2.2
Fear of dissatisfaction for the wife	1	3.7±3.6	1	0.5±0.5	–	–	1	1.6±1.6
Fear of appearing disabled before the eyes of an experienced female partner	1	3.7±3.6	–	–	–	–	–	–
Divulgence of infor-mation about sexual disability	–	–	1	0.5±0.5	1	0.8±0.8	–	–
Onanophobia	6	22.2±8.0	1	0.5±0.5	–	–	1	1.6±1.6
Fear of consequences of sexual abstinence	3	11.1±6.0	–	–	–	–	–	–
Iatrogenia	2	7.4±5.0	2	1.1±0.8	2	1.6±1.1	–	–
Reading of medical literature and acquaintance with medical documents	2	7.4±5.0	1	0.5±0.5	–	–	1	1.6±1.6
Information about pathogenic influence of microwave frequencies	1	3.7±3.6	–	–	–	–	–	–
Information about negative effects of anabolic hormones	–	–	1	0.5±0.5	1	0.8±0.8	–	–
Apprehension of a possible deterioration of sexual functions in prospect	1	3.7±3.6	–	–	–	–	–	–
Activation of recollections of previous sexual failures	1	3.7±3.6	–	–	–	–	–	–
Confidence in one's own unattractiveness	1	3.7±3.6	–	–	–	–	–	–

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cause of the «malfunction» in 16 patients (12.9±3.0%) could not be found out.

Analysis shows that all in all different variants of the «malfunctions», associated with physiological disruptions of sexual functions, were revealed in 101 patients (81.5±3.5%), this value reliably exceeding the number of true sexual disorders, which were the proximate cause of the sexual "malfunctions" with subsequent development of SAESF (respectively, 81.5±3.5% and 18.5±3.5%; p<0.001).

During calculation of the number of the factors, which ensured the sexual «malfunction», one cause was found out in 90 cases (72.6±4.0%), two in 16 (12.9±3.0%) and three in 2 (1.6±1.1%).

During the postmanifest development of SAESF (64 observations) 2 cases did not reveal any sexual "malfunctions" as such. Thus, one man simply lost its ability to repeat a coitus, while the other one did not regard the normal duration of a coitus as such and, as the result, SAESF developed. In 62 other observations with the real sexual «malfunction» their following causes were revealed, whose order in compliance with their rate decrease was as follows. True sexual disorders occurred most frequently (44 cases; 71.0±5.8%). Sexual abstinence and dysrrhythmia caused such «malfunction» in 6 cases (9.7±3.8%). Quarrels with the wife figured as often as the latter causative factor of the «malfunction». Fatigue and asthenization as causes, which resulted in the sexual disorder, were observed in 4 cases (6.5±3.1%), use of alcohol in 2 (3.2±2.2%), hypercontrol of penile erection in 1 (1.6±1.6%). Calculation of the number of causes, which ensured the sexual «malfunction» in this subgroup, demonstrated that 57 cases (91.9±3.5%) had one of them and 3 cases (4.8±2.7%) two. The cause of the «malfunction» in 2 patients (3.2±2.2%) could not be revealed.

The comparative analysis of the causes, which resulted in the sexual «malfunction», in the above two subgroups with the postmanifest (acute-subacute as well as gradual) development has shown that in the first case their number significantly prevails owing to pure «situational» ones. At the same time in the subgroup of patients with the gradual development of SAESF factors of the «chronic effect» significantly prevailed. For instance, true potency disorders were observed in this subgroup of patients reliably more frequently that in the subgroup with the acute-subacute development of SAESF (respectively, in 71.0±5.8% and 18.5±3.5%; p < 0.001). Besides, while in the group with the gradual development of SAESF quarrels with the wife as the cause of the sexual malfunctions were present in 6 cases (9.7±3.8%), in the group with the acute and subacute development of SAESF this causative factor was not registered at all.

CONCLUSION

There are many factors that can be involved in the formation of SAESF. Knowledge of their possible role in this process makes it possible to more effectively solve the problems of prevention of the syndrome.

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