SECTION: SEXOLOGY AND GENDER PSYCHOLOGY

РОЗДІЛ: СЕКСОЛОГІЯ ТА ГЕНДЕРНА ПСИХОЛОГІЯ

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HYPERSEXUALITY: A CLINICAL OBSERVATION

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A case history is presented, where hypersexuality could be conceptualized as a manifestation of persistent genital arousal disorder / restless genital syndrome [PGAD/ReGS]. Female patient Sh., 75, who sought our medical advice on April 16, 2015, presented complaints about a feeling of a "sexual drive in my pubic region", burning in her legs (along the inner surface of her thighs), in her pubis and on her abdomen over the pubis in a small area. "I need intimacy, but I understand with my head that it is not necessary for me". The above burning and sexual desire were felt, but not always. The appearance of the desire coincided with the appearance of the burning. At first, the burning developed and was followed by the desire, or on the contrary. The burning and desire could begin in the morning and trouble her all day long, but when she was engaged into some activity, she changed over and forgot about it. The appearance of the disorder was preceded with the death of her elder brother, who some time before was actually a substitute for her father. He always supported her both morally and financially. He was a rather valued personality for her, she loved him very much. Therefore, she took his death, which happened in the beginning of December in 2013, very hard. The disorder, concerning which the patient consulted me, appeared on February 14, 2014. She woke up in the night because of her heavy jittering, she felt a terrible sexual drive and a bad burning in her lower abdomen over the pubis and on the inner surface of her thighs. She could not sleep any more. The arousal, which appeared in the night, did not leave her till the morning and remained during the whole day, but then became weakening. She was treated by different medical specialists. Though some weakening of her symptoms was achieved, she failed to get rid of the disorder, which developed in her. As a result of our analysis we supposed its cerebrovascular genesis, which impacted on functions of the brain. As a weighty contributing factor we regarded her long-term distress caused by a manifested psychological trauma (the death of the person who was extremely significant for the patient). Our treatment (hypnosuggestive therapy, Sonapax, Hydazepam, irrigation of the pubis with 10% Lidocaine aerosol), where hypnosis was the main component (its 10 sessions were performed), resulted in complete disappearance of the symptoms. The interview performed 5 years after the end of the treatment demonstrated persistence and duration of the obtained results. The presented clinical case is not very bright, but this fact can be explained to a great extent by the patient's age that excluded appearance of a number of phenomena typical for PGAD/ReGS.

KEY WORDS: hypersexuality, clinical observation, woman, hypnosis, biological therapy.

At present, there are 4 conceptualizations of pathologic hypersexuality. Thus, it is conceptualized as a type of obsessive-compulsive disorder (OCD), sexual addiction (SA), a disorder of impulsivity, disorder in the form of persistent genital arousal (persistent genital arousal disorder [PGAD]) / restless genital syndrome [ReGS]) (Kocharyan G.S., 2019, 2020; Bancroft J., Vukadinovic Z., 2004; Carnes P., 1983; Irons R., Schneider Jennifer P., 1996; Orford J., 1985; Weiss Douglas, 1998).

Though each of the above conceptualizations (models) of hypersexuality in some cases explains its development and clinical manifestations better than others, only Code 6C92 "Compulsive sexual behaviour disorder" (CSBD), characterized by persistent inability to control intense and repetitive sexual impulses or sexual urges with resultant repetitive sexual behaviour, was included into the International Classification of Diseases, 11th Revision (ICD-11). Its symptoms can include

repetitive sexual actions, which become the chief centre of the person's life, up to neglection of one's own health and self-care or other interests, actions and duties. It has been reported that this disorder is also characterized by numerous unsuccessful attempts to make the repetitive sexual behaviour significantly rarer despite its unpleasant consequences and little or no satisfaction from it. It has been demonstrated that the pattern of inability to control intense sexual urges with resultant repetitive sexual behaviour manifests during a long period of time (for example. 6 months or more) and causes pronounced stress or significant disorders in one's personal, family, social, educational and professional spheres or other important fields of functioning (World Health Organization's. ICD-11, 2019).

In order to treat hypersexuality both biological treatment (Kocharyan G.S., 2019, 2020) and psychotherapy (Kocharyan G.S., 2019, 2020), particularly hypnosuggestive therapy, are used. Here we would like to present a case history from our clinical practice, where the existing pathology can be conceptualized as a manifestation of PGAD/ReGS. The key role in the treatment of the above case, which proved to be effective, was played by hypnosuggestive therapy.

Female patient Sh., 75, with a higher humanitarian education, had retired and did not work at that time. She sought medical advice on April 16, 2015. She had got one son, who lived in Russia and had got two children. She had been living with the man, who was older by 4 years than she was, for about 14 years. She was in a "common-law marriage" with him. This man graduated from military academy, held the rank of colonel (the same was held by her husband) and at that time was a retiree. She lived with him at her two-room flat.

Complaints and history. She presented complaints about a feeling of a "sexual drive in my pubic region", burning in her legs (along the inner surface of her thighs), in her pubis and on her abdomen over the pubis in a small area. "I need intimacy, but I understand with my head that it is not necessary for me". The above burning and sexual desire were felt, but not always. The appearance of the desire coincided with the appearance of the burning. At first, the burning developed and was followed by the desire, or on the contrary. In this case, no engorgement of her genital and mammary glands occurred, but before, when the disorder was more severe, the nipples of her mammary glands engorged. Now the sexual drive was expressed less than earlier. During arousal her vagina was not moistened. The burning and desire could begin in the morning and trouble her all day long, but when she was engaged into some activity, "I change over and forget about it".

Many years ago, a physician at a health resort taught her how to perform autogenic training (relaxation). In order to get rid of the symptoms that troubled her, she would relax and they disappeared. "When I'm lying or sitting, they trouble me to a far lesser degree. If I lie or sit down, my symptoms abate at once. Now, if I am engaged in something, I don't think about it at all". Before the beginning of her treatment in December of 2015 it did not help at all. Also, the patient said the following: "Well, I get up in the morning, and this man is sleeping in another bed in underpants. This arouses me, but I don't want him, because in order to make sex with man you should love him or he should "envelope" a woman". She asked her common-law husband not to walk near her semi-naked (in underpants).

At the age from 58 to 60 she lived a sex life with him. Then he underwent an operation on his prostate because of its adenoma, after that their sexual relationship discontinued for some time. "After its resumption I didn't reach orgasm in sexual intercourses during intimacy with my common-law husband because of his poor penile tension and other sexual disorders; I was irritable, quick-tempered and felt heaviness in my lower abdomen. Having tormented myself in this way for 2 years I urged that our sexual relationship should be broken off." Even more, the patient told her common-law husband that if he did not agree to her demand then they would have to part with each other. In general, the patient characterized the quality of their sexual relationship as "let's call it a sex life", because it paled into significance by the side of sexual contacts with her late husband, whom she married when she was 18 ("both the anatomy was another and the relations were of another kind"). At the moment of presentation, she lived with her common-law

husband like a brother and a sister. During all her life she had two men: her lost husband and her common-law husband.

Her desire was not induced by any nonsexual stimuli. Travelling by car or train, vibration from mobile phones or visiting the toilet did not result in aggravation of the symptoms. Any spontaneous orgasms and preorgasmic states were absent. She regarded the present symptoms as inappropriate, obsessive and undesirable.

She did not masturbate, and masturbation was not admissible for her. "I won't do it; I don't need it; these symptoms should be eliminated. I believe that even if I achieve orgasm it won't help me." Her last orgasm was during an erotic dream 5 years after the death of her husband (at the age of 53).

The relations with her husband were "beautiful" and their sex life was "excellent". When she was 48, her husband and their 20-year-old son perished in a car accident (they crashed in their own car). Then her menses ceased at once. She lived 10 years without man, because she "couldn't betray my husband". Later she was "coupled" with the man, with whom at the moment of presentation she lived together.

The appearance of the disorder was preceded with the death of her elder brother; he actually was a substitute for her father who fell during the Great Patriotic War. Whenever it was necessary he supported her both morally and financially. He was a rather valued personality for her, she loved him very much. Therefore she took his death, which happened in the beginning of December in 2013, very hard. For this reason ambulances visited her many times.

Before the above symptoms appeared, she did not fall down and did not have any injuries of her vertebral column.

The disorder, concerning which the patient consulted me, appeared on February 14, 2014. "I woke up in the night, because of my heavy jittering, I felt a terrible sexual drive and a bad burning in my lower abdomen over the pubis and on the inner surface of my thighs". And then I couldn't sleep any more, but rolled myself in a travelling rug and was sitting till the morning". Then there was not even a thought in her head to suggest the man, with whom she lived, engaging in sexual intercourse. "But he couldn't have done anything. At that moment I needed man, but he was not nearby". The arousal, which appeared in the night, did not leave her till the morning and remained during the whole day, but then became weakening. "On February 18, I visited a private gynaecology office. After his examination the physician prescribed me Omnadren 250 or Sustanon 250, Methyltestosterone [pay attention to the total inadequacy of administration of the male sex hormone in this case], fytor suppositories with sea buckthorn. Using all these medicines, I didn't feel any improvement. Then I had to visit a urologist, Candidate of Medical Science. After a bladder ultrasound (little inflammation was diagnosed in its cervix) the doctor prescribed me lavage of my bladder with hydrocortisone in combination with Dioxydine and suppositories with Gravadin into my vagina. I followed all prescriptions of my doctors, but didn't feel any improvement, the sexual drive and burning over my pubis and on the inner surface of my thighs didn't reduce. I became overstrung and irritable. Later I was treated by a professor of gynaecology, whom I found on my way of struggle for health. She took me with understanding and paid much attention to me. After a regular examination she prescribed me Climakterin, Deprivox, Bromvamphor, Persen, Hypothiazid, dried apricots, raisins, belladonna, St. John's wort and licorice. But this course of treatment didn't help me either. Being in despair, I went on looking for help. On April 4, I visited another professor of gynaecology at a medical institution. I was treated to August 3, 2014. I took Kleverol, Aphobazol, Climakterin and Deprivox. Also, Femoston hormone was included, but it caused haemorrhage in me. And again I turned out to be in the process of search. During my treatment I underwent MRI of my brain, spinal radiography, computed tomography of my urinary system, ultrasound of my thyroid gland, pelvic and visceral organs; I constantly took blood tests including those for different hormones. All the gynaecologists, who examined me, haven't revealed any pathology." In December of 2014 the patient was treated in one of cardiology centres of the city. She shared the problem with her physician in charge, who recommended her to take Buspirone (an anxiolytic), which she was taking during 4 months, and

Finlepsin (an antiepileptic agent). After that she consulted a neurologist, who prescribed her Lyrica (an antiepileptic and anticonvulsive agent) and later neogambin (a Ukrainian analogue of Lyrica). Later another neurologist prescribed her Cerebrolysin (it produces nootropic and neurometabolic actions), Ceraxon (a nootropic agent) intravasally and lysine (an essential amino acid), and then Ceraxon in sachets that she had been taking by now. Her state started to improve since December of 2014, that is after she began taking the above medicines at the cardiology department. After all this multi-staged treatment her symptoms reduced but did not disappear. Like before, she was constantly troubled by appearance of an undesirable and tormenting sexual desire as well as burning in her suprapubic region and along the inner surface of her thighs. Having not received the expected results, the patient decided to consult a psychotherapist, and in this way she came to us.

Platonic (romantic) libido. Its appearance failed to be revealed by the age of 17. She did not fall in love with anybody before she met her future husband. She fell in love with him when she was 17, but before she "didn't care a bean about the male sex at all". After that they dated for a year. He periodically came to the village, where she lived. At first they kissed each other's cheeks, went to the cinema. She married at 18. On the day, when they got married at a registry office, no sexual intercourse occurred because her husband left her for a week to take part in a military exercise. The intercourse took place one week later. Soon sexual libido appeared, orgasm developed in 3 months after the beginning of their sex life, and in this period of time she also got pregnant.

Menses. These started at the age of 17 (when she was growing and did not fast). Her menses were regular and accompanied with abdominal pains. The latter discontinued at 19 after she bore her first son. The menstruations lasted 3 days after 28 days without any disorders. Up to the age of 48 they were regular, but at 48 ceased at once after the tragedy with her husband and son.

At the moment of presentation the patient was diagnosed to have coronary heart disease and angina pectoris. She pointed out that she had attacks of paroxysmal tachycardia, bradycardia and extrasystole. A node was found in her thyroid gland, but its function was not affected. Four years before she survived a concussion (she hit her head in the flat). She said that she had a very good memory.

Abstract from case history dated September 10, 2012. Clinical diagnosis: cervicocranialgia, a mixed type; moderate pain syndrome; vertebral artery syndrome; cervical osteochondrosis, an unstable form; discirculatory atherosclerotic and hypertensive encephalopathy, stage 2, with intracranial hypertension, vestibulo-atactic syndrome and asthenic state.

Objectively: height = 164 cm, body mass = 80 kg; bra size = 4 (but she began from 1); no hypertrichoses and hair stream from her pubis to her navel were observed.

The following data of paraclinical methods of examination were presented.

Thyroid ultrasound (October 27, 2014). Conclusion: multinodular goiter, stage 1.

Hormonal investigations [progesterone, total testosterone, follicle-stimulating hormone (FSH), estradiol (E2)] (March 19, 2014). Total testosterone = 4.47 nmol/l (the norm for women over 50 = 0.101-1.42). As for the rest, no abnormalities were detected.

Hormonal investigations [prolactin, total testosterone, estradiol (E2)] (May 12, 2014). No abnormalities were detected.

Hormonal investigations (August 29, 2014). Prolactin = 11.69 ng/ml (the norm for nonpregnant women = 4.79-23.3 ng/ml).

Hormonal investigations (October 17, 2014). Thyroid stimulating hormone (TSH) = 3.36 mcIU/ml (the norm for adults = 0.27-4.2 mcIU/ml); free thyroxin (FT4) = 2.08 ng/dL (the norm for adults = 0.93-1.7 ng/dL).

Transvaginal ultrasound of pelvic organs (May 13, 2014). Conclusion: no voluminous pathology is detected.

Magnetic resonance imaging of the brain (March 18, 2015). Conclusion: focal changes in the white matter of the frontal lobes – probably, manifestations of cerebral microangiopathy. The "empty" Turkish saddle is forming. Secondary dilation of the subarachnoid space of the ventricles

against a background of a reduced volume of the substance in the hemispheres. Moderate manifestations of catarrhal polysinusitis. MRI signs of previous left-sided otitis.

Ultrasound examination [liver, gallbladder, pancreas, spleen, kidneys, urinary bladder] (March 17, 2014). Conclusion: no organic pathology is detected.

Heart ultrasound (January 22, 2015). Conclusion: sclerotic changes in the aorta, left ventricular hypertrophy, left atrial enlargement.

Multislice computed tomography of the urologic region (May 13, 2014). Conclusion: CT signs of renal cysts, liver cyst.

Administrations:

1. Sonapax (25 mg tab.) at an ascending dose: day 1 – ½ tab. 2 times, day 2 – ½ tab. 2 times, day 3 – ½ tab. 3 times, later 1 tab. 2 times a day, and after that 1 tab. 3 times a day.

2. Hypnosuggestive therapy.

April 20, 2015. She noted that at that time she felt burning in the whole abdomen over her pubis (it involved the whole abdomen over the pubis with a wide expansion of that feeling upwards, to the right and left) as well as on the inner surface of her thighs and in her back. Also, some "partial sexual desire" existed. The appearance of burning in her back and spreading of the region of burning over her pubis versus the complaints on presentation could be attributed to the fact that the taking of Finlepsin and Buspirone by the patient was cancelled, but the dose of Sonapax (I prescribed with a gradual increase) was still small.

April 20, 2015. The first session of hypnosuggestive therapy was given. The following suggestions were made: the apprehension and anxiety leave her; her organism is filled with rest; she is calm and even-tempered always and everywhere; her brain structures, responsible for sexual drive, calm down, get inhibited and fall asleep, therefore the above sexual drive leaves her, goes away and dissipates; the burning in her abdomen, on the inner side of her thighs and in her back leaves, goes away and dissipates.

The patient pointed out that immediately after the given session all unpleasant feelings and sexual arousal smoothed down.

April 22, 2015. Her state improved, the sexual arousal troubled less, the unpleasant feeling (burning) was present only in the suprapubic region (a small area), and there was no burning in other places. If compared with the state in the beginning of the treatment, the severity of her disorder reduced by 30%.

April 22, 2015. The second session of hypnosuggestive therapy was given. By the content of therapeutic suggestions it completely corresponded to the first session, but additionally (the patient complained about disturbance of her sleep) a suggestion towards its normalization was made.

Immediately after the given session all the symptoms disappeared. It was recommended to supplement Sonapax treatment with application of Menovasine on her pubis. Besides, in order to alleviate the burning, it was recommended to use irrigation of the pubis with 10% Lidocaine aerosol on the pubic region 2-3 times a day.

April 24, 2015. She noted that during 2 days after the 2nd session of hypnosis she did not feel any sexual arousal or burning at all, but in the morning the burning appeared just over her pubis with the desire. She pointed out that those two symptoms manifested themselves by 4 points (of the 10 points, which took place before the beginning of the treatment).

April 24, 2015. The third session of hypnosuggestive therapy was given. By the content of therapeutic suggestions it was the same as the second one, but it ended with additional suggestions towards reduction of sensitivity of nerve endings in the region of pubis and its anaesthesia as well as reduction of sensitivity of the nerves supplying the pubis and its adjacent regions.

Immediately after the end of the hypnotic session all her symptoms (burning, sexual drive) disappeared. Answering numerous questions the patient stated that even in case of some light pressure on her pubis the sexual arousal increased. It was recommended to substitute Phenazepam for Sonapax.

April 27, 2015. She failed to get Phenazepam, because it belongs to narcotic substances. Her neurologist and therapeutist did not want to prescribe it for her. At that time the patient took Sonapax by 25

mg thrice a day. "There is some vague, slight and non-exerting desire" and some burning in her suprapubic region on a small area. A day before nothing troubled her at all. Two days before she felt a very light desire and burning over her pubis, and the same was on that day. The severity of her disorders by the 10-point system was 3 points. She had already begun using Lidocaine spray. A day before she sat with the man, with whom she lived together, on a sofa and, unlike before, did not respond to him at all. "With my head I recognize that I don't need it. When I touch my genital organs during intimate washing, I don't have any desire, though it is caused by pressing on my pubis; but yesterday, however, after a pressure on my pubis the desire was practically absent." She noted that Sonapax caused dryness in her mouth and the feeling of instability when walking. Last three days she took only 1 tab. (25 mg) of Sonapax a day.

April 27, 2015. The fourth session of hypnosuggestive therapy was given, which by its scenario fully corresponded to the third one.

It was recommended to take Hydazepam (1 tab. = 0.02 g) by 2 tab. 2-3 times a day as well as to irrigate the pubic region using an aerosol with Lidocaine. The taking of Sonapax was cancelled.

April 30, 2015. She took Hydazepam (2 tab. by 0.02 g in the morning and in the evening). I suggested taking the medicine in the morning and in the daytime, because the above symptoms did not trouble her in the evening. On the day after the fourth session (on Monday) nothing troubled her at all, the same happened both on Tuesday and Wednesday. But that morning (on Thursday) she felt a slight burning, but then even a very deep pressure on her pubis did not cause any desire. The patient pointed out that when on that day she acted on her clitoris it produced pleasant sensations (some bliss, some minimum desire, which passed away very rapidly). I explained to her that the appearance of such sensations in case of the above action should be regarded as normal.

The patient informed: "When all this began with me I was ready to have everything excised [she meant her genital organs], only not to be troubled with it. Now I can live with it after I began being treated by you, while before I would agree to run my head into the snare (not completely, i.e. not to commit suicide, I'm speaking in images)."

After she discontinued taking Sonapax there was no dryness in her mouth and imbalance. All the time she slept well (I made proper suggestions for her). There was not any suprapubic burning in the morning. She was afraid that the pleasant sensations in the region of her clitoris, which she had felt on that day, might result in relapse of her symptoms again.

The fifth session of hypnosis was given. Its scenario was the same as during the fourth session. The following suggestions were made as special: "Your brain structures, responsible for sexual drive and sexual arousal, calm down… They calm down, get inhibited and fall asleep… Therefore the sexual drive and sexual arousal become weaker, leave you, go away, dissipate and remain in the past… The nerves, which are in the vicinity of the pubis and supply it, calm down, the sensitivity of nerve endings located in the pubis and suprapubic region reduces…Anaesthesia develops in the pubis region, sensitivity in the suprapubic region decreases… Your burning leaves the suprapubic region, goes away, dissipates and remains in the past…"

Every time during hypnosis the patient dropped minimally into its second stage.

May 4, 2015. She said that Hydazepam, which she then took by 0.05 g twice a day, made her reel. Before she took it at smaller doses and everything was normal. It was recommended not to take Hydazepam on that day any more (before her visit to me she had already taken 0.05 g of Hydazepam) and beginning from next day take ½ tab. of Hydazepam (1 tab. = 0.05 g) plus Antistress by 1 capsule twice a day. Last time she visited me on Thursday. After the hypnosis session on Thursday nothing troubled her, the same was on Friday and Saturday, but on Sunday evening the sexual desire appeared and rapidly disappeared after distraction of attention. On that day the above desire (**without her desire!)** appeared in the morning. Then those were transitory desires, which rapidly disappeared after distraction of attention. During all 5 days after the 5th session of hypnosis she did not feel any burning in her suprapubic region and on the inner surface of her thighs. Then a pressure on her pubis did not cause any sexual desire/arousal.

May 4, 2015. The sixth session of hypnosuggestive therapy was given. The suggestions were targeted at fixation of disappearance of sexual drive and burning in the suprapubic region that "went away, dissipated, were forgotten". An emphasis was made on the fact that it had happened before. No suggestion towards reduction of sensitivity in the region of her pubis, its nerve receptors and development of anaesthesia in it was made.

May 8, 2015. In the morning of May 5, 2015 her sexual desire appeared, but rapidly (about 10 minutes later) disappeared. It was concentrated in her suprapubic region. She characterized it as a "pleasant obsession, but undesirable for me." No burning was present. She pressed on per pubis, but it did not cause any sexual desire. At that time she did not respond sexually to her common-law husband, shower and genital hygiene and did not use an aerosol with Lidocaine. Earlier (before she consulted me) her drive was constant and undesirable. "I feel well, I've become an absolutely another person". She said that already the first session of hypnosis exerted a very strong positive effect on her. At that time she took Hydazepam by 0.025 g twice a day and Antistress by 1 capsule 2 times a day.

May 8, 2015. The seventh session of hypnosuggestive therapy was given. The same suggestions as during the previous session were made.

May 15, 2015. During one week after the given session no sexual drive appeared. It appeared on that day in the morning, but it was minimum and transitory (during 5 minutes). Immediately after its appearance she took Hydazepam. No burning was present. Any pressure on her pubis and intimate washing did not cause the desire. Her common-law husband did not trigger any sexual emotions either.

May 15, 2015. The eighth session of hypnosuggestive therapy was given. The same suggestions as during the previous session were made.

May 22, 2015. A day after the session she developed some slight desire, which lasted 15 minutes. It disappeared at once as soon as she sprayed an aerosol with Lidocaine on her pubis. Three days later the desire appeared again. It was controlled with Hydazepam and Antistress. In the morning the desire appeared again, but smoothed down by itself after 10 minutes. Its intensity by the 10-point scale was 0.5-0.6 points. Within that whole period no burning occurred.

May 22, 2015. The ninth session of hypnosuggestive therapy was given. The same suggestions as during the previous session were made.

May 29, 2015. She noted that a day after the session and 3 days after it as well as that morning she had the sexual drive, which lasted 15 minutes and went away after her pubis was sprayed with Lidocaine aerosol. The severity of the sexual drive was the same as she mentioned during her previous visit. The sexual desire appeared over her pubis. ***That was not any general desire, but the one, which appeared just in that region, "I believe that it is directly inside my pubis".*** The patient informed that she was reeling very much and suffered from excessive sleepiness. She sprayed her pubis with Lidocaine aerosol. I cancelled taking of Antistress capsules.

May 29, 2015. The tenth session of hypnosuggestive therapy was given. As for special suggestions, the following ones were made: "The structures and cellules of your brain, which are responsible for severity of the sexual drive, calm down… They calm down, get inhibited and fall asleep… Therefore the sexual drive and sexual arousal go away, dissipate; leave your organism and remain in the past… Unpleasant sensations in your suprapubic region and in the region of the inner surface of your thighs have become things of the past… This burning has left your organism, gone away, dissipated and remained in the past…"

The patient called me 2 days later and said that she felt very well (she did not have any drive, any burning, any sleepiness, any reeling). She was recommended to spray her pubis with Lidocaine aerosol 2 times a day (in the morning and in the evening) during 10 consecutive days.

In conclusion it should be noted that in view of the acute onset of the analysed disorder we may ***suppose (!)*** its cerebrovascular genesis, which impacted on functions of the brain. As a weighty contributing factor we should name long-term

distress caused by a manifested psychological trauma (the death of the person who was extremely significant for her).

Positive shifts in the dynamics of the above disorder began appearing in the process of her treatment at a cardiology inpatient department, when she was administered an anxiolytic and an antiepileptic agent. Nevertheless the complete normalization of her state (this refers to the characterized pathology) was achieved only after the treatment provided by us (hypnosuggestive therapy, a mild neuroleptic agent, a tranquillizer, anaesthesia of the pubic region).

The presented clinical case is not very bright, but this fact can be explained to a great extent by the patient's age that excluded appearance of a number of phenomena typical for the above pathology. The interview performed on **April 10, 2020**, i.e. 5 years after the end of the treatment, demonstrated persistence and duration of the obtained results.

REFERENCES

Kocharyan G. S. (2019). Биологическая терапия больных с гиперсексуальностью [Biological therapy of patients with hypersexuality], *Zdorov'ye muzhchiny, No 3 (70),* 43–46, DOI: https://doi.org/ 10.30841/2307-5090.3.2019.185357 (in Russian).

Kocharyan G. S. (2020). Гиперсексуальность [hypersexuality]. Kharkov: OOO «DISA PLYuS», 263 s. (in Russian).

Kocharyan G. S. (2019). Гиперсексуальность: термины, диагностические подходы, концептуализация, распространенность [Hypersexuality: terms, diagnostic approaches, conceptualization, prevalence], *Zdorov'ye muzhchiny, No 2 (69),* 61–68. DOI: https://doi.org/10.30841/2307-5090.2.2019.179977 (in Russian).

Kocharyan G. S. (2019) Психотерапия больных с гиперсексуальностью [Psychotherapy of patients with hypersexuality], *Zdorov'ye muzhchiny, No 4 (71)*, 44–51. DOI: https://doi.org/10.30841/2307-5090.4.2019.195262 (in Russian).

Bancroft J., Vukadinovic Z. (2004). Sexual addiction, sexual compulsivity, sexual impulsivity, or what? Toward a theoretical model, *J Sex Res, 41 (3)*, 225–234.

Carnes P. (1983). Out of the shadows: Understanding sexual addiction. Minneapolis, MN: CompCare.

Irons R., Schneider Jennifer P. (1996). Differential Diagnosis of Addictive Sexual Disorders Using the DSM-IV, *Sexual Addiction & Compulsivity, 3*, 7–21.

Orford J. (1985). Excessive appetites: A psychological view of the addictions. Chichester, England: John Wiley & Sons, 1985.

Weiss Douglas. (1998) The Final Freedom: Pioneering Sexual Addiction Recovery. Fort Worth, Tex.: Discovery Press.

World Health Organization's. ICD-11: Compulsive Sexual Behavior Disorder. URL: https://www.yourbrainonporn.com/miscellaneous-resources/world-health-organizations-icd-11-compulsive-sexual-behavior-disorder/ (the date of the reference: 25.03.2019).

ГІПЕРСЕКСУАЛЬНІСТЬ: КЛІНІЧНЕ СПОСТЕРЕЖЕННЯ

Г. С. Кочарян

Харківська медична академія післядипломної освіти

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Наводиться історія хвороби, де гіперсексуальність можна було концептуалізувати як прояв розладу в формі постійного генітального збудження (persistent genital arousal disorder) / синдрому роздратованих статевих органів (restless genital syndrome) [PGAD / ReGS]. Хвора Ш., 75 років, яка звернулася до нас за лікувальною допомогою 16.04.2015 р., пред'явила скарги на відчуття «статевого потягу в області лобка», печіння в ногах (по внутрішній поверхні стегон), в лобку і на животі вище лобка на невеликій площі. «Мені потрібна близькість, але головою розумію, що мені це не треба». Печіння і сексуальне бажання бувають не завжди. Поява бажання збігається з виникненням печіння. Спочатку з'являється печіння, а потім бажання, або навпаки. Печіння і бажання можуть початися з ранку і турбують протягом всього дня, але коли чимось зайнята, то перемикається і забуває про це. Появі розладу передувала смерть старшого брата, який свого часу практично замінив їй батька. Він завжди допомагав їй і морально, і матеріально. Для неї він був дуже значущою особистістю, вона його дуже любила. Тому його смерть, яка трапилася на початку грудня 2013 року, вона дуже важко переживала. Розлад, з приводу якого пацієнтка звернулася до мене, виник 14 лютого 2014 р. Вночі прокинулася, її сильно трясло, відчула сильний сексуальний потяг і сильне печіння внизу живота над лобком та на внутрішній стороні стегон. Не могла спати. Збудження, що виникло вночі, не відпускало її до ранку і зберігалося на наступний день, але потім почало слабшати. Лікувалася у різних лікарів. Хоча було досягнуто деяке ослаблення симптоматики, але позбутися від розладу, який розвинувся у неї, вона не змогла. В результаті проведеного аналізу ми припустили його цереброваскулярний генез, що відбилося на функціонуванні головного мозку. В якості вагомого сприяючого фактора розглядали тривалий дистрес, обумовлений вираженою психотравмою (смерть надзвичайно значущою для пацієнтки людини). Проведене нами лікування (гіпносугестивна терапія, сонапакс, гідазепам, зрошення лобка 10% аерозолем лідокаїну), головним компонентом якої був гіпноз (проведено 10 його сеансів), призвело до повного зникнення симптоматики. Опитування, проведене через 5 років після закінчення лікування, свідчить про стійкість і

тривалість отриманих результатів. Наведений клінічний випадок не є дуже яскравим, проте це в значній мірі можна пояснити віком пацієнтки, що виключало можливість появи низки феноменів, характерних для PGAD / ReGS.
КЛЮЧОВІ СЛОВА: гіперсексуальність, клінічне спостереження, жінка, гіпноз, біологічна терапія.

ГИПЕРСЕКСУАЛЬНОСТЬ: КЛИНИЧЕСКОЕ НАБЛЮДЕНИЕ

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Приводится история болезни, где гиперсексуальность можно было концептуализировать как проявление persistent genital arousal disorder) / restless genital syndrome) [PGAD / ReGS]. Больная Ш., 75 лет, которая обратилась к нам за лечебной помощью 16.04.2015 г., предъявила жалобы на ощущение «полового влечения в области лобка», жжение в ногах (по внутренней поверхности бедер), в лобке и на животе выше лобка на небольшой площади. «Мне нужна близость, но головой понимаю, что мне это не надо». Жжение и сексуальное желание бывают не всегда. Появление желания совпадает с возникновением жжения. Вначале появляется жжение, а потом желание, или наоборот. Жжение и желание могут начаться с утра и беспокоят в течение всего дня, но когда чем-то занята, то переключается и забывает об этом. Появлению расстройства предшествовала смерть старшего брата, который в свое время практически заменил ей отца. Он всегда помогал ей и морально, и материально. Для нее он был весьма значимой личностью, она его очень любила. Поэтому его смерть, которая случилась в начале декабря 2013 г., она очень тяжело переживала. Расстройство, по поводу которого пациентка обратилась ко мне, возникло 14 февраля 2014 г. Ночью проснулась, ее сильно трясло, почувствовала сильное половое влечение и сильное жжение внизу живота над лобком и на внутренней стороне бедер. Не могла спать. Возникшее ночью возбуждение не отпускало ее до утра и сохранялось на следующий день, но потом начало ослабевать. Лечилась у различных врачей. Хотя было достигнуто некоторое ослабление симптоматики, но избавиться от развившегося у нее расстройства она не смогла. В результате проведенного анализа мы предположили его цереброваскулярный генез, отразившийся на функционировании головного мозга. В качестве весомого способствующего фактора рассматривали длительный дистресс, обусловленный выраженной психотравмой (смерть чрезвычайно значимого для пациентки человека). Проведенное нами лечение (гипносуггестивная терапия, сонапакс, гидазепам, орошение лобка 10% аэрозолем лидокаина), главным компонентом которой был гипноз (проведено 10 его сеансов), привело к полному исчезновению симптоматики. Опрос, проведенный спустя 5 лет после окончания лечения, свидетельствовал о стойкости и длительности полученных результатов. Приведенный клинический случай не является очень ярким, однако это в значительной степени можно объяснить возрастом пациентки, что исключало возможность появления ряда феноменов, характерных для PGAD / ReGS.
КЛЮЧЕВЫЕ СЛОВА: гиперсексуальность, клиническое наблюдение, женщина, гипноз, биологическая терапия.