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SEXUAL DISORDERS: A BEHAVIORAL APPROACH TO THEIR FORMATION AND THERAPY

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A behavioural model of sexual disorders is based on the principles of behavioural psychology, according to which these disorders are regarded as a result of acquired forms of behaviour fixed in the process of learning. Undesired or disadaptive sexual patterns (for example, avoidance of intimacy, dependence on certain objects or situations for arousal) can result from negative experience, reinforcement or absence of adequate learning. Behavioural therapy is intended for elimination of learned forms of behaviour (symptoms and syndromes). It is based on the principle, according to which it is possible to get rid of any unhealthy or inadequate manifestation (symptom) with a reflex origin following the same way. Therefore, the goal of behavioural therapy consists in destruction of pathological behavioural programmes and formation of normal ones, which are adjusted to reality. The article presents behavioural models of formation of sexual disorders: I. P. Pavlov's model of classical conditioning (formation of conditioned reflexes); model of operant conditioning (awards: positive and negative reinforcement, punishment); A. Bandura's model of social learning (the learning takes place when watching behaviour of other people, as well as under the influence of media). The author characterizes determinants of formation of sexual disorders in a behavioural model, gives examples of different sexual dysfunctions and sexual orientation disorders, which develop by behavioural mechanisms. Behavioural interventions used for therapy of sexual disorders are presented, and the author's behavioural scheme of using medications for treatment of anxious sexual failure expectation syndrome is suggested.

Keywords: *sexual disorders, behavioural models, determinants of formation, clinical examples, behavioural interventions, behavioural pattern of medication use.*

Introduction

The behavioral model of sexual disorders is based on the principles of behavioral psychology, according to which these disorders are considered to be the result of acquired forms of behavior reinforced in the learning process, and unwanted sexual responses or their absence may be the result of emerged associations, reinforcements, or avoidance.

Undesirable or maladaptive sexual patterns (e.g., avoidance of intimacy, dependence on certain objects or situations for arousal) may be the result of negative experiences, reinforcement, or lack of adequate learning.

Behavioral therapy is designed to eliminate learned forms of behavior (symptoms and syndromes). Behavioral therapy is based on the principle that any painful or inappropriate manifestation (symptom) that has arisen reflexively can be eliminated by following the same path. Thus, the goal of behavioral therapy is to destroy pathological behavioral programs and form normal ones that are adapted to reality.

In sexopathology, examples of established pathological programs include premature ejaculation, which developed as a result of a constant fear of being caught unexpectedly while masturbating, which the man had done before; accelerated ejaculation, which arose as a result of the existing need to quickly stop intimate contact due to his wife's illness; the syndrome of coded sexual reactions, described by K. Imelinsky; exhibitionism, fetishism, other paraphilias, and homosexuality, which arose through conditioned reflexes.

Behavioral models of sexual disorders offer a pragmatic view of their origin and maintenance. Understanding how negative learning shapes sexual behavior provides a solid foundation for developing targeted and effective interventions.

Behavioral models of sexual disorder formation

The following three models of sexual disorder formation are distinguished:

1. I. P. Pavlov's classical conditioning model.

This theory explains the formation of conditioned reflexes by the almost simultaneous influence of conditioned and unconditioned stimuli (ideally, the influence of the conditioned stimulus should slightly precede the unconditioned stimulus). This model assumes that sexual responses can be conditioned by certain stimuli. If sexual arousal or orgasm is repeatedly associated with unpleasant or traumatic events, these negative associations can suppress the natural sexual response. The following case can be cited as an example. A person who has experienced sexual violence may feel anxiety or disgust in situations that were previously associated with sexual arousal. Their body has associated these situations with

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danger, leading to the suppression of physiological arousal (Google Gemini, 2025, June 19).

2. Operant conditioning model.

The theory of operant conditioning was developed by Edward Thorndike and Frederick Skinner. Operant learning is based on Skinner's fundamental principle: behavior is shaped and maintained by its consequences. In operant conditioning, behavior can be changed by the stimuli that follow it (rewards and punishments). It should be clarified that rewards include both "positive reinforcement" and "negative reinforcement." Positive reinforcement is when a person receives something desirable or interesting for themselves for a "correct" action, and negative reinforcement is when a person is freed from something unpleasant for themselves for a "correct" action.

Sexual behavior that is accompanied by positive reinforcement (pleasure, intimacy) will have a tendency to repeat itself. Conversely, behavior that is accompanied by punishment (e.g., sexual reproaches and insults from a partner) will decrease or be avoided. Example: A man who has repeatedly experienced failure during sexual intercourse due to erectile dysfunction may begin to avoid sexual intercourse so that this failure does not happen again and he does not experience disappointment (Google Gemini, 2025, June 19).

3. Albert Bandura's social learning model.

This model emphasizes the role of observation and imitation in shaping sexual behavior. We learn by observing the behavior of others, whether it be parents, peers, or media content. Examples of the formation of sexual disorders include unrealistic expectations of sex formed by pornography, which can lead to disappointment and feelings of inadequacy if real sexual experiences do not meet these expectations (Google Gemini, 2025, June 19).

Determinants of sexual disorder formation in the behavioral model

The following main determinants of sexual disorder formation in the behavioral model are identified (Google Gemini, 2025, June 19.):

Learned behavioral responses. Undesirable or maladaptive sexual patterns (e.g., avoidance of intimacy, dependence on certain objects or situations for arousal) may be the result of negative experiences, reinforcement, or lack of adequate training.

Formed associations. Negative sexual experiences (pain, shame, fear) can lead to the formation of negative behavioral patterns, where previously pleasant stimuli (e.g., intimacy with a partner) begin to cause anxiety or disgust.

Avoidant behavior. Many sexual disorders are characterized by avoidance of situations associated with sexual activity or sex itself. Although this avoidance reduces anxiety in the short term, in the long term it reinforces dysfunction and prevents new positive experiences.

Lack of skills. In some cases, sexual dysfunctions may be related to the absence or underdevelopment of necessary sexual skills, including communication with a partner and the ability to express one's desires and needs, as well as a lack of knowledge about one's body and reactions.

The role of the partner and interaction. Sexuality is often an interpersonal phenomenon. The behavioral model also considers how interaction with a partner (or lack thereof), the partner's reactions, and the dynamics of the relationship affect sexual behavior and function.

The role of external stimuli and reinforcement. The behavioral model focuses on how external stimuli (e.g., certain situations, people, objects) can elicit or inhibit sexual response. Reinforcement plays a key role in the consolidation or extinction of a particular behavior. For example, if sexual activity is accompanied by anxiety or pain, it can lead to avoidant behavior.

The "stimulus-response" model. It is based on the idea that certain stimuli (external or internal) elicit certain responses (physiological, emotional, behavioral). In sexual disorders, this connection may be disrupted. The goal of therapy is to change this connection and teach the patient new, more adaptive responses.

Focus on the present and specific problems. The behavioral model focuses on current behavior and its change. The therapist and patient work together to identify specific problems, set goals, and develop strategies to achieve them.

Sexual disorders formed by behavioral mechanisms

1. Sexual dysfunctions.

Sexual dysfunctions that can develop through behavioral mechanisms include erectile dysfunction, ejaculation disorders, sexual arousal disorders in women, manifested, in particular, by a decrease or absence of lubrication, and disorders of sexual desire and orgasm. Sexual dysfunctions in ICD-10 also include vaginismus and dyspareunia, which, however, in ICD-11 were separated into a separate group – "sexual pain disorders." Behavioral factors may also contribute to the formation and development of sexual pain disorders of inorganic and mixed nature. It should be noted that behavioral mechanisms are often combined with cognitive ones. In these cases, we should talk about a cognitive-behavioral model of sexual dysfunction formation.

I will cite my following clinical observation, which concerned erectile dysfunction that developed due to behavioral mechanisms. Patient M., 29 years old, said that he had previously had problems with penile tension. During the interview, it became clear that he had been practicing martial arts for a long time. The patient noted: "Any physical exertion is performed on the exhale, and we practiced that if I miss a blow to the body, I need to exhale as sharply as possible. At the same time, the abdominal muscles tense up (on the exhale), and then the blow is easier to withstand. Otherwise, it can knock the breath out of you or even send you to the ground or knock you out. As a result, as a negative consequence of this training, during intimacy with a woman, when she touched my stomach, especially unexpectedly for me, I would exhale, and my abdominal muscles would tense sharply. As a rule, this led to a sharp decrease or even disappearance (not permanently, but for a while) of my erection. Before this first occurred, the patient had a sex life, but it was

irregular. After this phenomenon appeared, it persisted for another six months, until he began to have a regular sex life. When he began to have sex regularly, after 8-10 sexual acts with the same woman, this disorder was eliminated. Since his erection was restored quickly, he did not consult a doctor. In addition, he notes that not only touching his abdomen caused a weakening of his erection, but also touching his thigh. It is clear that normalization in this case occurred spontaneously as a result of the fading of the pathological sexual reflex.

My other clinical observation concerns a case of premature (early) ejaculation that developed due to behavioral mechanisms. A man sought medical help complaining of premature ejaculation, which developed in him due to the following circumstances. For several years, he was forced to have sexual intercourse very quickly, as his wife experienced severe pain during intercourse due to inflammatory gynecological pathology. Due to this pain, sexual intercourse only took place when he was no longer able to tolerate the high level of sexual tension that required release. His wife was later cured, but the stereotype of quickly ending sexual intercourse became firmly established, which led him to seek help from a sexologist (Kocharyan, 2012).

Another patient of mine attributed his premature ejaculation to the fact that during masturbation, which he engaged in as a teenager, he always sought to reach orgasm quickly. At the same time, he had no fear of being caught by his parents.

Renowned American sexologists Masters and Johnson (1970) report that many young Americans have their first sexual experience with a professional prostitute, for whom rapid ejaculation is a positive phenomenon: the sooner her first client leaves, the sooner she can take the next one and the more she will ultimately earn. Other young Americans who have their first sexual experience with casual acquaintances in random and often unfavorable settings (in a park, in a car, etc.) are again "rushed" by both their girlfriends, who fear accidental witnesses, and the unfavorable circumstances themselves. Everything and everyone rushes the young American, and the habit of finishing sexual intercourse as quickly as possible turns into a firmly established conditioned reflex, which he cannot always get rid of after getting married.

Anejaculation can also develop through behavioral mechanisms. This can happen if, as a result of systematic masturbation, a clear pattern of ejaculation has developed as a result of certain stimuli that cannot be reproduced during sexual intercourse. In some cases, although the form of stimulation of the penis is similar to that which occurs during sexual intercourse, due to the absence of a set of familiar erotic stimuli that cannot be fully reproduced during coitus, we may be talking about anejaculatory sexual intercourse. For example, I observed a young man who sought help due to the absence of ejaculation during coitus, as a result of which he and his wife did not have children. Upon questioning, the reason for this turned out to be the following. It turned out that, starting from adolescence, he had been masturbating regularly for a number of years. Moreover, he still sometimes "slips up" and masturbates. His nonverbal reactions showed that it gave him great pleasure. This was confirmed by a targeted interview, which revealed that he experiences much more pleasant sensations during masturbation than during sexual intercourse with his wife. In addition, it turned out that during masturbation he experiences both ejaculation and orgasm, which does not happen during sexual intimacy (Kocharyan, 2007).

As an illustration of the pathological stereotype formed as a result of masturbation, I can also cite the following clinical observation. Patient U., 38 years old, complained of loss of penile erection approximately 2-3 minutes after insertion into the vagina and the start of friction. Ejaculation during intimate relations never occurs. Active questioning revealed no libido disorders. He has been masturbating since the age of 18. At first, he masturbated regularly once a day, then several times a week. Then he switched to a rhythm of once a week. Every time he masturbated, starting from the very first time, he experienced ejaculation and orgasm. He last masturbated last year. He notes that his masturbation technique was "normal" (he used his hand, bent into a fist, for friction). During masturbation, he imagined having sex with women in different positions, rarely using playing cards with images of naked women for erotic stimulation. During active, targeted questioning, he notes that when he masturbates, he experiences maximum pleasure in the penis area. At the same time, he has a full erection, followed by ejaculation and orgasm. When his wife stimulates his penis (this was included as part of sex therapy), he "feels greater pleasure in his brain and throughout his body, but his penis reacts very sluggishly to her stimulation." He repeats and clarifies that when he masturbates, the opposite is true: "the penis becomes aroused, but there are no pleasant waves of arousal until almost the last moment" (when ejaculation is about to occur). Only then does "the whole body feel it." He also notes that during friction in the vagina, he only feels that his penis is "sliding" (moving), but there are no pleasant sensations (everything is limited to ordinary tactile sensations), and the tension in his penis disappears over time.

The formation of a pathological sexual stereotype is illustrated by my next clinical observation. Patient K., 25 years old, has a sexual partner (in a "civil marriage" for 2.5 years). She complains that she gets more pleasure from watching internet pornography combined with masturbation than from sexual intercourse with her partner. When masturbating, she clamps the blanket between her legs. She also reaches orgasm during sexual intercourse, but when masturbating, it comes faster, is stronger, and is of "higher quality." She wants to experience the same intense sensations with her partner. During intercourse, her sexual arousal is not as pronounced as during masturbation. She has not told her partner that she prefers the computer (masturbation combined with internet pornography) to him (Kocharyan, 2017).

The following example demonstrates the absence of orgasm during sexual intercourse in a woman, which developed due to behavioral mechanisms. One of my

patients, aged 28, did not experience orgasm during sexual intercourse with either of her two husbands (she is now divorced). Her repeated attempts to experience orgasm during intimate contact with other men were also unsuccessful. At the same time, she is capable of experiencing up to 30 or more orgasms after squeezing her muscles of thighes for some time, placing one thigh on top of the other. It turned out that this woman first experienced orgasm in this way at the age of 8 and still systematically resorts to this form of sexual self-gratification (Kocharyan, 2006).

We can also talk about the influence of a complex of physical stimuli, including tactile ones, which are characterized by a certain intensity, temperature, and other parameters that, by themselves, and even more so in combination, cannot be reproduced during sexual intercourse. As an example, I can cite a fragment of the medical history of one of my patients. A young woman who sought medical help due to the absence of orgasm said that she and her husband had tried various sexual techniques and positions, but despite the fact that her husband had very good potency and could easily prolong sexual intercourse, all attempts to bring her to orgasm were unsuccessful. It turned out that when she was a girl, she would direct the shower stream at her genitals while masturbating. At first, she just felt pleasant sensations, but then gradually began to experience orgasms. At the time of seeking medical help, it turned out that she could easily induce orgasm in herself in exactly the same way (Kocharyan, 2006).

Vasilchenko (1977) gives an example of the formation of a pathological sexual stereotype in a 38-year-old patient, Yakh., who recently got married and turned out to be sexually incompetent. He had never been sexually active before. His wife's caresses never caused an erection, but he had very strong erections when using the toilet. He began masturbating at the age of 15. For the first 1–1.5 years, he sometimes imagined a female image while masturbating. Then, for more than 20 years, he masturbated mechanically, without the use of fantasy. He most often had to masturbate in toilets. He notes that until recently, the specific smell of the toilet, the sound of pouring water, shiny toilet bowls, the sight of tiled floors, as well as the sight of the glans penis exposed from the foreskin caused a strong desire to masturbate, accompanied by pronounced erections.

Although this case was initially considered untreatable, the patient was advised to refrain from any attempts at sexual intercourse for a week or two, explaining to his wife that he needed rest to get rid of his neurasthenia. At the same time, it was recommended that he systematically take a separate room in the bathhouse 1-2 times a week for hygienic washing and visit it with his wife, also without making any attempts at intimacy. At the same time, the patient had to behave in such a way that his wife believed that this was just a regular hygienic visit to the bathhouse.

During his first visit to the bathhouse, Yakh. had such a strong erection that he violated the existing condition, although his wife did not initially arouse him sexually and the beginnings of his arousal appeared only before ejaculation. The next day, Yah managed to use his morning erection for sexual intercourse, because only with the passage of time did his wife's caresses and even the mere sensation of her body begin to arouse lustful feelings, followed by erections. The following diagnosis was made: disruption of sexual conditioned reflex complexes (due to their vicious formation as a result of prolonged masturbation).

Examples of sexual dysfunctions that develop through behavioral mechanisms include pathoreflexive and dysregulatory forms (Kryshtal, 2008). The first case involves the fixation and reinforcement of sexual failure, which is then repeated. In the second case, we are talking about sexual dysfunction that has developed as a result of the practice of interrupted sexual intercourse to prevent pregnancy.

ehavioral fixation of sexual dysfunction is also reflected in the category of "urogenital sexological disorders complicated by persistent disruption of nervous regulation mechanisms." In this case, we are talking about a patient who was treated for chronic prostatitis, one of the manifestations of which was premature ejaculation. Despite the sanitation of the prostate gland, this sexopathological symptom does not disappear because it has become fixed and a corresponding pathological sexual stereotype has formed. This form of disorder is referred to as the syndrome of secondary pathogenetic titularization.

Here is another example of existing sexual problems that persisted after the elimination of the causes and conditions that originally caused them. Patient B., 47 years old, is in a "common-law marriage." His main sexual complaint was a loss of sexual desire, which could be explained by the fixed effects of stress associated with his divorce from a woman who had cheated on him. The treatment, the main component of which was hypnosuggestive therapy, led to a rapid recovery (Kocharyan, 2024).

Here is another example from my clinical practice, where the patient's sexual problems at the time of referral were a persistent aftereffect that remained after the causes that initially caused them had been eliminated. Patient Ch., 30 years old, married, noted that she did not experience spontaneous sexual desire and arousal. They only occurred during cunnilingus. At the same time, her erotic libido was completely preserved. She had sexual relations with her husband 5-6 times a week and only on his initiative. Before her first childbirth, she was very passionate and had no sexual dysfunction. Her interest in sex disappeared 5-6 months into her first pregnancy. She resumed her sex life 1.5 months after her first delivery. Since then, in addition to the absence of a spontaneously growing desire for sexual intercourse, she has had insufficient vaginal lubrication. She is gynecologically healthy. She has no chronic diseases. I linked the patient's sexual problems to her first pregnancy. However, after giving birth, there were no changes in her sexuality. Due to the absence of obvious somatic causes of sexual dysfunction, as well as the effectiveness of hypnosuggestive therapy (the final diagnostic conclusion was based on the results of treatment), I concluded that the patient's sexual

dysfunctions were the result of existing inertial shifts in the body, which preserved the sexual dysfunctions that were initially caused by factors related to pregnancy. A program (stereotype) of sexual responses had formed, which persisted for a long time, despite the absence of factors associated with the first pregnancy. Five sessions of hypnosuggestive therapy (programming, modeling) were conducted, which was the dominant element of treatment. The results showed complete elimination of sexual problems (Kocharyan, 2023).

2. Changes in sexual orientation.

These changes can also be shaped by behavioral mechanisms. According to behavioral theories, the process of sexual orientation boils down to the development of psychological conditioned reflexes at an early age, combined with positive or negative reinforcement for certain sexual behaviors. Thus, people's early sexual experiences can lead them toward homosexual behavior as a result of pleasant sexual contacts with members of their own sex that bring satisfaction, or unpleasant, disappointing, or even frightening heterosexual experiences.

Behavioral theory suggests that paraphilia can result from accidental conditioning. If sexual arousal is repeatedly associated with a non-sexual object or situation, they may themselves begin to cause arousal over time. The formation of paraphilias can be influenced by, in particular, (Google Gemini, 2025, July 11):

• ***Traumatic childhood experiences:*** emotional, physical, and sexual abuse, neglect, dysfunctional family relationships.

• ***Learning and reinforcement:*** association of atypical stimuli with intense sexual arousal at an early age, as well as masturbatory fantasies that reinforce and intensify such arousal.

• ***One-time or repeated negative sexual experiences and copying of observed behavior patterns.***

The formation of paraphilias through behavioral mechanisms is often explained by conditioning processes (Google Gemini, 2025, July 15). If a person regularly experiences sexual arousal in the presence of a certain object not related to sex (for example, shoes), the brain may begin to associate shoes with this arousal. Eventually, shoes alone may become a sufficient stimulus for sexual arousal, forming fetishism. Behavior that is followed by positive reinforcement (pleasant sensations, orgasm, release of tension) becomes more likely to be repeated in the future. Conversely, behavior that is followed by punishment or a lack of the desired outcome becomes less likely to be repeated. If a person accidentally discovers that certain non-traditional sexual behavior (e.g., exhibitionism) leads to strong sexual arousal or orgasm, this action is "reinforced," increasing the likelihood of its repetition.

If non-traditional sexual behavior reduces discomfort, anxiety, or internal tension, this is also a form of reinforcement. For example, if compulsive sexual behavior (as in some paraphilias) temporarily relieves internal anxiety, this may contribute to its reinforcement. Additional behavioral factors that may contribute to the development of paraphilias include (Google Gemini, 2025, July 15):

• ***Observational learning.*** A person can learn paraphilia behavior by observing others or using media resources. If the observed behavior is associated with pleasure or getting what one wants, it can encourage imitation.

• ***Avoidance and ritualization.*** In some cases, paraphilic behavior may develop as a way to avoid more complex or anxiety-provoking situations (e.g., intimacy with a partner) or as part of a ritual that provides a sense of control or predictability.

• ***Fantasies and masturbation.*** Repeatedly linking sexual fantasies to specific paraphilic themes during masturbation can reinforce these associations and cement them in the behavioral repertoire.

It is important to note that the formation of paraphilias is usually a complex interaction of many factors, including biological, psychological and also social, and behavioral mechanisms may only be part of it.

Patient K., 21 years old, has been living with a 22-year-old girl for 1 year. He sought medical help due to a periodically arising desire to masturbate using porn featuring transsexuals/transvestites. My examination led me to conclude that this patient, as a result of prolonged masturbation using non-normative pornographic videos featuring transsexuals/transvestites, developed a pathological sexual behavioral stereotype, which is manifested by the need for the above-mentioned non-normative masturbation, as well as a decrease in sexual arousal and a weakening of orgasm during heterosexual sexual intercourse (Kocharyan, 2022).

Holstein and Schudze (1983) report a case of pedophilia to illustrate the role of masturbation and masturbatory fantasies in the development and fixation of this paraphilia. Svyadoshch (1988) cites examples where the combination of sexual arousal and masturbation with with peeping sex scenes led to the development of voyeurism (visionism, scopophilia) in a woman, and a woman's examining of a man's penis led to exhibitionism in a man.

Behavioral interventions in the treatment of sexual disorders

To eliminate sexual disorders, the behavioral approach uses (Google Gemini, 2025, June 19):

• ***"Sensory focusing".*** This is a series of exercises aimed at reducing anxiety about sexual performance and refocusing attention on sensory experiences. Couples take turns touching each other without focusing on sexual intercourse, gradually expanding the boundaries of tactile contact.

• ***Progressive muscle relaxation.*** This involves using it to reduce the overall level of anxiety and tension that often accompany sexual dysfunction.

• ***Social skills/communication training.*** This improves communication between partners, especially regarding sexual needs and desires.

• ***Graduated influence (exposure therapy).*** Gradually increasing (controlled) exposure to fearful situations or situations that are avoided is carried out in order to reduce

anxiety. Gradual influence (or systematic desensitization) is a behavioral psychotherapy method used to reduce anxiety and fear of certain objects, situations, or activities. The method is based on the controlled presentation of anxiety-provoking stimuli, which are gradually intensified, in combination with relaxation techniques.

• ***Modification of sexual behavior.*** This leads to a change in maladaptive habits and the introduction of new, healthier behavioral strategies.

To eliminate erectile dysfunction, sex therapy, which is based on sexual behavior training, can use sensory focusing; To get rid of premature ejaculation (PE), the "squeeze technique" proposed by James Semans in 1956 can be used. This technique was modified by W. Masters and V. Johnson. The "stop-start exercise," also developed by James Semans in 1956, is also used to eliminate PE (Kocharyan, 2012). To get rid of anejaculation in men and anorgasmia in women, the "bridge" technique proposed by H. S. Kaplan is used (Kocharyan, 2018), and for vaginismus, plastic dilators are used, the sizes of which are gradually increased (Kocharyan, 2021).

Hypnosuggestive therapy, which combines the hypnotic method with the principles of behavioral therapy, is successfully used to treat various sexual dysfunctions of non-organic origin (decreased and increased libido; erection, ejaculation and orgasm dysfunctions; vaginismus, dyspareunia). It aims to change behavioral patterns by putting the patient into a hypnotic state, helping them to form new, more adaptive responses. For this purpose, both hypnosuggestive programming and hypnosuggestive modeling are used (Kocharyan, 2013; Kocharyan, 2024). In the process of such therapy, maladaptive programs are eliminated and normal programs of sexual functioning are formed. Hypnosis suggestive therapy in a behavioral context is also used for the treatment of paraphilias.

Neurolinguistic programming (NLP) is also actively used to change sexual behavior programs (Kocharyan, 2002). In particular, the following NLP techniques are used for this purpose: the "swish technique", the "compulsion blowout technique", and developed by me the "technique of correction of behavioural programmes". This technique also includes a cognitive component.

In clinical sexology, the aversive method (unlearning method) is used to treat paraphilias (in particular, fetishism, transvestism, sadism, and pedophilia). It can be carried out using emetics (apomorphine) and electric discharges. These two approaches are also used to change unwanted homosexual orientation to heterosexual orientation. In the latter case, the following may be used. Electric discharges are delivered by a device powered by a 9-volt battery, and the patient himself sets the tolerable level of shock, which is delivered through a cuff electrode to the biceps or calf area. This method is in no way comparable to electroconvulsive therapy, which uses 70-120 volts and electrodes placed on the head, causing a grand mal seizure and often complications in the form of serious memory impairment (Kocharyan, 2020).

The following techniques related to masturbation are used to treat pedophilia (Kocharyan, 2017):

1. Orgasmic reorientation. It was first described in detail by Marquis (1970) in men and is aimed at increasing sexual desire when seeing adult women. In these cases, pedophilic fantasies are combined with masturbation, and as orgasm approaches, the patient switches to images of adult women. The resulting orgasm, as believed in this approach, promotes the development of heterosexual sexual desire when this technique is used repeatedly. If a person was able to do this successfully several times, they were encouraged to gradually shift from fantasies associated with this deviant behavior to heterosexual fantasies, which were "turned on" earlier and earlier until they were able to ejaculate using only them.

2. The "masturbation oversaturation" technique was developed later (Marshall, 1979; Abel et al., 1984). It includes 2 stages: initially masturbation is carried out with the using of heterosexual porn, and after orgasm occurs, pedophile porn is used, which causes unpleasant sensations, since we are talking about refractory period. As a result, arousal under the influence of pedophilic stimuli, as believed, gradually decrease.

Of course, the two techniques mentioned above can also be used to treat other types of sexual orientation disorders.

To change sexual orientation from homosexual (which the man wants to get rid of) to heterosexual, as one of the components of correction, I recommend that patients change homosexual-oriented masturbation to heterosexual masturbation, as well as masturbation using images of naked women and women masturbating. When using heterosexual scenes, I recommend that they focus on female images. The use of lesbian scenes, which heterosexual men resort to, is not prohibited.

For the sexual reorientation of homosexuals-egodistonic, bisexuals, as well as those who do not consider homosexuality to be a pathology but who wish to become heterosexual in order to start (or not disrupt) a family and have children, I use hypnosuggestive therapy in the form of programming and modeling. Programming includes suggestion to get rid of homosexual attraction, filling with heterosexual attraction, as well as changing the aesthetic and sexual perception of female and male individuals, strengthening sexual attraction to girls and women (in men). Modeling is connected later. The person sees themselves in an intimate setting: there is caressing and kissing, followed by sexual intercourse. Thus, we are talking about acquiring, albeit imaginary, experience of heterosexual contact. With repeated hypnotic sessions, homosexual attraction weakens and even disappears, while heterosexual attraction intensifies (Kocharyan, 2021).

Use of drug therapy included in the behavioral scheme

I propose the use of medications included in the behavioral scheme (Kocharyan, 2019) for the treatment of anxious sexual failure expectation syndrome (ASFES).

I tell patients who have had ASFES for a certain period of time that their unsuccessful attempts to engage in sexual intercourse have resulted in the formation of a pathological program, which manifests itself in repeated failures when attempting to engage in sexual intercourse (a kind of pathological habit). I note that this program needs to be

changed to a healthy one. To this end, I propose the following treatment regimen. One to three times before attempting coitus, the patient should take a medium dose, for example of sildenafil (50 mg) one hour before the planned sexual intercourse. The next one to three times, this dose is 25 mg, and then 12.5 mg for the next one to three times. At the same time, approximately 1.5 hours before sexual intercourse, he should take a tranquilizer, for example, 20 or 50 mg of gidazepam (depending on the severity of anxiety/fear of sexual failure). This forms a program for the normal course of sexual intercourse. After that, sildenafil is discontinued, but the patient is advised to keep this pill or part of it nearby, which will give him confidence that even if he fails (which is very unlikely), he will still be able to perform full sexual intercourse 1 hour after taking this drug. However, it is the presence of this pill that will give him confidence in his sexual abilities and his ability to perform quality intercourse. We usually do not recommend that men with ASFES tell their partners that they are using such potent substances (sildenafil, vardenafil, tadalafil), because in these cases, positive results may be attributed by women to these drugs, and not to men (leading to a devaluation of the partner's sexual abilities).

Conclusions

Based on the above data, it can be concluded that various sexual disorders can often develop completely or partially due to behavioral mechanisms. After analyzing their formation in each individual case, it is necessary to prescribe the appropriate behavioral therapy that can be effective.

Conflicts of interest. The author declare that they have no conflicts of interest.

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СЕКСУАЛЬНІ РОЗЛАДИ: ПОВЕДІНКОВИЙ ПІДХІД ДО ЇХ ФОРМУВАННЯ І ТЕРАПІЇ

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Поведінкова модель сексуальних розладів ґрунтується на принципах поведінкової психології, згідно з якими ці розлади розглядаються як результат набутих форм поведінки, закріплених у процесі навчання. Небажані або дезадаптивні сексуальні патерни (наприклад, уникнення інтимності, залежність від певних об'єктів або ситуацій для збудження) можуть бути результатом негативного досвіду, підкріплення або відсутності адекватного навчання. Поведінкова терапія призначена для ліквідації завчених форм поведінки (симптомів та синдромів). В основу поведінкової терапії покладено принцип, згідно з яким будь-якого хворобливого або неадекватного прояву (симптому), що виник рефлекторно, можна позбутися, слідуючи цим же шляхом. Таким чином, метою поведінкової (біхевіоральної) терапії є руйнування патологічних та формування нормальних, пристосованих до дійсності поведінкових програм. У статті наведено поведінкові моделі формування сексуальних розладів: модель класичного обумовлення І. П. Павлова (формування умовних рефлексів); модель оперантного обумовлювання (нагороди: позитивне і негативне підкріплення, покарання); модель соціального навчання Альберта Бандури (навчання відбувається при спостереженні за поведінкою інших людей, а також при впливах медіа). Характеризуються детермінанти формування сексуальних розладів в поведінковій моделі, приклади різних сексуальних дисфункцій і порушень сексуальної орієнтації, що розвиваються за поведінковими механізмами. Наводяться поведінкові інтервенції, які використовуються для терапії сексуальних розладів, та запропонована автором поведінкова схема використання медикаментів для лікування синдрому тривожного очікування сексуальної невдачі.
Ключові слова: *сексуальні розлади, поведінкові моделі, детермінанти формування, клінічні приклади, поведінкові інтервенції, поведінкова схема використання медикаментів.*

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