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METHODOLOGICAL APPROACHES TO PROVIDING MEDICAL CARE FOR PATIENTS WITH SEXUAL DISORDERS

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There are different methodological approaches to the therapeutic support of patients with sexual dysfunctions (erection-centered, orgasm-centered, pleasure-centered). According to the first, the most important thing for sexual life is a good erection, according to the second – the presence of orgasm. In our opinion, the pleasure-centered approach to psychotherapeutic support for patients with sexual dysfunctions, proposed by us, is the most humanistic and has a pronounced psychoprotective potential. However, this approach does not in any way exclude measures to normalize sexual functions (including erection and orgasm) in cases where this is possible. The described approach is very useful in cases where, for one reason or another, erection, orgasm, as well as other sexual functions, can't be fully or partially normalized. The approach of Masters and Johnson (1970) includes the mandatory need to involve a sexual partner in the examination and treatment of a patient with sexual dysfunctions. It is quite natural that if we are talking about treatment in another system, it can be carried out without couples sexual training. It should be remembered that any healthy idea can be taken to logical absurdity. This can occur with a specialist who does not work within the Masters and Johnson approach, but requires strict adherence to the couple principle during therapy. This can occur with a specialist who does not work within the Masters and Johnson approach, but requires strict adherence to the couple principle during therapy. In our opinion, the couple approach consists in taking into account the interests of each specific couple and each of its members and can be carried out both with and without the involvement of the second partner. The requirement of mandatory involvement in all cases of the second partner is incorrect, stereotyped, sometimes discriminatory, discredits the couple approach and in a number of cases leads to a violation of human rights to receive medical care.
Keywords: *sexual dysfunctions; medical care; methodological approaches*

Introduction

The effectiveness of medical care for patients with sexual dysfunctions is determined by conceptual approaches to providing this care. In this article, we will present various methodological approaches to providing such assistance. We will first discuss three paradigms of this type of assistance, and then examine the dyad approach separately. The following paradigms of this care can be identified.

Erection-centric paradigm

When doctors work with patients who have sexual dysfunctions, it can often be observed that medical care is based on an approach that focuses on normalizing erections, which determines the possibility of sexual intercourse. In addition to this approach being dictated by the demands of the patient and its sexual partner, numerous advertisements for modern drugs aimed at restoring erections contribute to the strengthening and popularization of this approach (Kocharyan, 2016, 2018).

Orgasm-centered paradigm

This paradigm emerged later. Volodimirov-Klyachko (1972) raised the question of the need to use deep petting in the treatment of sexual disorders and disharmonies, which guarantees the occurrence of orgasm in a woman, relieving the man of responsibility for the quality of sexual intercourse, and thus neutralizes the factor of anxiety/fear of sexual failure. A woman's confidence that she will reach climax is a desirable prerequisite for her sincere encouragement and support of her partner when he experiences difficulties. The idea of the value of using petting for therapeutic and rehabilitative purposes was then widely promoted by Liebig (1990). Justifying the need for its use, the author notes that historically, the idea of the leading role of penile erection in sexual contact has developed. At the same time, as Liebig emphasizes, the main indicator of a quality sexual act is orgasm. The essence of the technique he recommends boils down to the following. During the first conversation with a man and a woman separately, they are asked in detail about what they expect from their sex life. They express their requirements by filling out a questionnaire. Then, during a conversation with both partners, a general petting program (a kind of "contract") is drawn up, differentiated for each couple, which takes into account the previous sexual experience of the man and woman. In accordance with the principle of paradoxical psychotherapy, normal sexual intercourse is prohibited at this stage. In the case of psychogenic erectile dysfunction, the use of deep petting can lead to its elimination, since the tension of the penis is ignored as a component of sexual intercourse, eliminating the syndrome

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of anxious expectation of sexual failure. This often leads to partners violating the "ban" on normal sexual intercourse.

Pleasure-centered paradigm

Based on our experience in helping patients with sexual dysfunctions, we have concluded that the pleasure-centered paradigm we propose best meets the needs of providing this assistance (Kocharyan, 2016, 2018). Its essence lies in the fact that the main thing in intimate relationships is to obtain pleasure. During sexual intercourse with a good erection, long duration of intercourse, adequate technique, or when using deep petting, orgasm is not always achievable. We have been approached many times by women who do not experience orgasm despite the good potency and sexual technique of their sexual partners. Concerned about its absence, they experience severe distress and seek sexological help. When examining these women, it is often found that, despite the absence of orgasm, they derive pleasure from caresses, kisses, and sexual intercourse [retardation and constitutional forms of anorgasmia according to Svyadoshch (1991)]. After sexual intercourse, these women do not experience any discomfort. In a number of observations, such women's requests for sexological help may be due to the fact that they learn about other women's orgasms, which causes them to feel envious ("why doesn't this happen to me?").

One young woman (a part-time student) who came to us for help had come to take her next exam session at one of the universities in Kharkiv, and there her roommates in the dormitory told her that they had orgasms. She had never experienced them and was very disappointed. When the patient came to see me, she was extremely upset, although, as it turned out during the interview, she experienced pleasant sensations during sexual contact with her husband, was aroused, and after intercourse did not feel any discomfort and felt very good.

In such cases, we provide the following psychotherapeutic assistance. The woman's attention is focused on the fact that she experiences pleasure during intercourse, and her appeal to the fact that other women experience orgasm, which causes her pronounced anxiety, is a consequence of her envy of them. We focus her attention on the fact that the main thing in the process of intimacy is her ability to experience pleasure. This pleasure can be significantly diminished by the mindset of having an orgasm, the expectation of achieving it, and the fear that she will not be able to experience it again. In addition, we inform the patient that after a woman experiences an orgasm, she may often lose interest in further intimacy, while the patient herself is able to enjoy it for quite a long time.

Sexually healthy women do not always experience orgasm during intimate relations, but in a number of such cases, they are able to enjoy themselves and do not experience any discomfort after intercourse. The focus on a quality erection sufficient for vaginal intercourse, as well as the mandatory achievement of orgasm, may be unacceptable for very elderly people who can enjoy caresses, kisses even with weakened or even absent erection. In the context of this article, it should be noted that the latest American Diagnostic and Statistical Manual of Mental Disorders (DSM-5, 2013) reports that, in general, sexual satisfaction does not correlate strongly with orgasmic experience. Many women report high levels of sexual satisfaction despite rarely experiencing orgasm or even when they do not experience it at all.

It is also worth quoting psychologists Yarhouse and Ten (2016), who note that among women who have difficulty reaching orgasm, only half are seriously concerned about it. This suggests that, despite its importance, orgasm is not necessarily a key component of intimacy for women.

Conclusions

There are different approaches to the therapeutic support of patients with sexual dysfunctions (erection-centered, orgasm-centered, pleasure-centered). In our opinion, the pleasure-centered approach to psychotherapeutic support for patients with sexual dysfunctions is the most humanistic and has a pronounced psychoprotective potential. However, this approach does not in any way exclude measures to normalize sexual functions (including erection and orgasm) in cases where this is possible.

A COUPLE'S APPROACH TO THE TREATMENT OF SEXUAL DISORDERS

There are varying attitudes regarding whether partners of patients with sexual dysfunctions should be involved in the evaluation and treatment.

The approach of Masters and Johnson

It should be noted that Masters and Johnson (1970) developed a system of sex therapy for sexual disorders, which is the main therapeutic factor involves the use of various sexual techniques, requiring the mandatory participation of the sexual partner in therapeutic training. Drug therapy in their approach is rarely prescribed and only as an adjunct. The mandatory couple approach was borrowed from these authors by some clinical sexologists, who refused to prescribe treatment to patients who sought help without a sexual partner.

Is it mandatory to involve a partner in the treatment of a patient's sexual disorder?

Later therapeutic masturbation, which did not require the presence of a partner, also began to be used in sex therapy. It is quite natural that if we are talking about treatment in another system, it can be carried out without paired sexual training.

The use of medications, especially modern ones, as well as various psychotherapeutic methods (for example, hypnosuggestive therapy and neurolinguistic programming) can ensure good therapeutic results in many cases even without the involvement of sexual partners. Of course, involving a partner in the examination increases the doctor's diagnostic capabilities, as it allows them to look at the problem from two sides (through the eyes of both partners). However, it should be remembered that any healthy idea can be taken to logical absurdity. This can happen to a specialist who does not work with the Masters and Johnson approach, but requires the mandatory participation of the partner in therapy. The approach to

examination and treatment of patients with sexual problems should not be formal, but differentiated, taking into account specific circumstances. During the examination of one man, he was diagnosed with "neurosis of expectation of failure." At the same time, it turned out that his wife reacted very negatively to her husband's sexual disorder (reproaches, scandals, offensive statements), which led to his even greater fixation on performing sexual intercourse and, of course, aggravated his sexual disorder. In these cases it is imperative to invite the wife for a conversation, since the appropriate therapy without changing her behavior is likely to be ineffective. Attempts to invite the partner for a conversation may be met with her unwillingness to talk to a specialist.

This may be due to both a lack of understanding of her role in supporting her husband's sexual disorder and an unwillingness to continue the relationship with him. In the first case, she usually tells her husband: "You are sick, go and get treatment, I have nothing to do with it." In these cases, we give the patient the following recommendation: "Tell your wife/partner that the doctor wants to meet with you to discuss my health condition." If the woman is interested in continuing sexual relations with this man, then this invitation is accepted. Here is another example. A patient comes for a consultation because he is afraid that he will not be able to perform sexually when attempting sexual contact with each new partner. Usually he cannot perform sexual intercourse during the first two sexual acts due to erectile dysfunction, but then his function normalizes. What would the examination of this patient look like if he were required to involve a partner with whom he had recently met and with whom he did not have an established relationship? In addition, it is unknown how she would react to the patient's statement before intercourse that he experiences failure every time he attempts contact with a new woman (Kocharyan, 2014).

In such cases, for the first sexual intercourse to be successful, it is advisable to prescribe sildenafil citrate, vardenafil, tadalafil, or udanafil to the patient some time before coitus, which may be supplemented with tranquilizers 1.5-2 hours before the planned sexual intercourse. In this way, we will not only improve blood flow to the penis, but also alleviate anxiety/fear of sexual failure. If these conditions are met, the first sexual intercourse will proceed normally, which will ensure the full course of subsequent coitus, even without the use of medication.

We have repeatedly encountered cases where the wives of patients interpreted their disorders as a consequence of the loss of feelings for them, the loss of their attractiveness to husbands, or as a result of the appearance of a mistress in the husband. Some men in these cases did not want to tell their wives the truth, because, in their opinion, this would humiliate their male dignity in the eyes of their wives. The behavior of the wives in these cases during and outside of intimacy was not psychotraumatic for the man, and the prescribed treatment led to the complete normalization of his sexual function. Therefore, in these circumstances, it is not necessary to insist on the obligatory visit of the wife to the doctor (Kocharyan, 2014).

Sexual problems can also bother patients who do not have partners. In these cases, it is hardly advisable to refuse them examination and treatment on this basis, suggesting that they consult a doctor only with a partner after she appears.

Conclusions

In our opinion, the couple approach consists in taking into account the interests of each specific couple and each of its members and can be carried out both with and without the involvement of the second partner. The requirement of mandatory involvement in all cases of the second partner is incorrect, stereotyped, sometimes discriminatory, discredits the couple approach and in a number of cases leads to a violation of human rights to receive medical care (Kocharyan, 2014).

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МЕТОДОЛОГІЧНІ ПІДХОДИ ДО НАДАННЯ МЕДИЧНОЇ ДОПОМОГИ ПАЦІЄНТАМ ІЗ СЕКСУАЛЬНИМИ РОЗЛАДАМИ

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Існують різні методологічні підходи до терапевтичної підтримки пацієнтів із сексуальними дисфункціями (ерекційно-орієнтований, оргазмо-орієнтований, задоволення-орієнтований). Згідно з першим, найважливішим для сексуального життя є хороша ерекція, згідно з другим – наявність оргазму. На нашу думку, запропонований нами підхід до психотерапевтичної підтримки пацієнтів із сексуальними дисфункціями, орієнтований на задоволення, є найбільш гуманістичним і має виражений психопротекторний потенціал. Однак цей підхід жодним чином не виключає заходів щодо нормалізації сексуальних функцій

(включаючи ерекцію та оргазм) у випадках, коли це можливо. Описаний підхід дуже корисний у випадках, коли з тієї чи іншої причини ерекція, оргазм, а також інші сексуальні функції не можуть бути повністю або частково нормалізовані. Підхід Masters і Johnson (1970) передбачає обов'язкову необхідність залучення сексуального партнера до обстеження та лікування пацієнта із сексуальними дисфункціями. Цілком природно, що якщо йдеться про лікування в іншій системі, його можна проводити без сексуального тренінгу пар. Слід пам'ятати, що будь-яку здорову ідею можна довести до логічного абсурду. Це може статися зі спеціалістом, який не працює в межах підходу Мастерса і Джонсон, але вимагає суворого дотримання принципу парності під час терапії. На нашу думку, парний підхід полягає у врахуванні інтересів кожної конкретної пари та кожного з її членів і може здійснюватися як із залученням другого партнера, так і без нього. Вимога обов'язкової участі у всіх випадках другого партнера є неправомірною, стереотипною, іноді дискримінаційною, дискредитує парний підхід і в низці випадків призводить до порушення прав людини на отримання медичної допомоги.
Ключові слова: *сексуальні дисфункції; медична допомога; методологічні підходи.*

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