low susceptibility subjects.

Looking at those subjects who scored fairly well before training (ie, the 'natural highs') two subjects showed a sharp drop in responsiveness following training. In subsequent discussion both of these subjects were highly critical of the CSTP, saying that it encouraged them to fake their responses and to respond in a manner that was quite different from their normal manner of responding , which was essentially to allow the suggestions to work by themselves. However, the other 5 high susceptibility subjects did not appear to have been disturbed by the program and enjoyed the challenge of a new approach. The passive strategy to hypnosis is certainly quite different from the active approach advocated by the CSTP, which suggests that the latter approach may not be suitable for all subjects. This finding reinforces the view of Sheehan and McConkey (1982) that there are many ways of responding to hypnotic suggestions and in trying to impose a particular strategy the CSTP may be counterproductive, particularly for those subjects who already have a successful method of responding.

In conclusion, the CSTP is certainly a breakthrough in hypnotic training, however, further research in different laboratories is necessary to clarify the variables contributing to its success. Future research might also profitably explore more flexible training procedures in order to take into account pre existing skills of the individual subject. The long term prognosis of the skill is also a central issue requiring further attention. Finally, more attention needs to be given to the practical implications of training for clinical practice, for example, in pain control, where such training procedures could be valuable in helping patients to make full use of pain control strategies.

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# Ericksonian Approach to Male Impotence

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■ *This study presents an extensive experience with a special, short term, hypnotherapy method based on indirect suggestions according to Milton Erickson's verbalization (1979). The indirect suggestions are preferred to the direct ones since they evoke no resistance. During the period 1975-1986 a total of 390 patients suffering from psychogenic impotence participated in the study. All were screened for FSH, LH, testosterone, NPT, prolactin, thyroid functions, and 13 patients were found to have abnormal levels of any of these hormones and were excluded from hypnotherapy. Of the remaining 377 patients, 366 had secondary impotence and 11 primary impotence. Most patients were at the ages 30-45 and the range was 20 to over 60 years. The average number of treatment sessions was 3.9 for the whole group, for ages 20-25 old 3.0, and for those over 60 years 5.6 sessions. All patients were followed for 12-18 months. For the secondary impotence cases 344 (94.5%) showed complete remission of symptoms, 5 (1.4%) had partial improvement and 15 (4.1%) failed to respond. For the primary impotence group the corresponding results were: complete recovery - 5 (45%), partial - 1 (10%) and no response - 5 (45%).*

Impotence is rapidly being recognized as one of the most common problems facing the male today. It has always been present but in the last few decades it has come increasingly to the attention of clinicians and researchers. There appear to be two basic reasons in the growing awareness and incidence of impotence:

1. People are more comfortable in discussing sexual dysfunction.
2. The woman acts a more aggressive sexual role which is extremely threatening to the male.

Definition: Impotence can be defined simply as the inability to execute the sexual act

obtain or maintain an erection sufficient for penetration into the vagina and perform the sexual act (Nuland, 1978). Some authors include premature ejaculation in their definition of impotence (Rothman, 1972, Crasilneck and Hall, 1975, Kroger, 1976). Masters and Johnson (1970) broaden the definition and also include partially impotent men whose rate of failure at successful coital connection exceeds 25% of their opportunities. Impotence can be primary, meaning that the patient had never been successful in obtaining an erection during sexual intercourse, or secondary, meaning that impotence appeared after a variable period (even many years) of adequate sexual behavior. This paper deals only with impotence without including premature ejaculation.

Almost every man encounters a few episodes of inability to achieve an erection despite his will. These episodes occur in different situations like physical or emotional exhaustion, states of anxiety, after alcohol or drug abuse, etc. These are not considered as true impotence. Situations like decreased libido toward the wife due to an extramarital affair, or unconventional sexual behavior like excessive masturbation or homosexual relations are not considered impotence.

The exact incidence of impotence is unknown mainly because of insufficient published data. Kinsey et al. (1948) report an incidence of 1.5% of impotence in adult males. In this series there were very few young people suffering from impotence but the numbers grew with age, achieving 20% at the age of 60. It is difficult to accept these figures as being valid nowadays; and this for two main reasons. Modern living became much more stressful than 40 years ago and people are now more open to discuss and admit their sexual inadequacies (Ward, 1980).

Etiology: only a few of the patients with secondary impotence demonstrate any relevant organic disorder. The etiology in most of the patients is purely psychogenic. Such problems as unsolved oedipal conflicts (Kaplan, 1974), disharmony between parent with either maternal or paternal predominance (Masters and Johnson, 1970) and latent homosexuality were found in patients suffering from impotence and revealed in psychoanalysis.

The following factors are the main cause of impotence:

a) Environmental factors such as excessive tiredness or other physical depressive upsetting circumstances, frequently a fear of interruption by children or relatives, mixed motivation in which the man may be attempting intercourse with an unsuitable partner to whom he has no real emotional attraction, and alcohol or drug ingestion.

b) Interpersonal relation: an impaired relation with the usual sexual partner. A divorce or death of a partner can change the whole way of living causing a loss of security and self-confidence and lead to impotence. However, even a temporary decline in family life can cause the same symptoms. Sometimes a lack of understanding of the husband's physiology and psychology, like teasing the husband about his manhood or sexual performance, can be a trigger for impotence.





c) Conversion symptoms: some sexual dysfunctions seem to be conversion symptoms. Conversion implies that a conflict in one area is expressed in the language of another, usually a psychological conflict showing itself not in words of feeling but in bodily symptoms. In a wider sense, sexual conversion symptoms may be expressed in the language of penile erection, feelings of adequacy and inadequacy that have their true origin in other non-sexual fields or experience. For example, a healthy man who is disabled through an accident that prevents him from returning to his usual work. Such a man may become withdrawn, experiencing a loss of self-esteem which was previously based on this work, productivity or earning ability. Such a man also becomes, not infrequently, impotent on a conversion basis, the impotence reflecting feelings of diminished potency in other areas.

d) Age: Kinsey et al.(1948) found that the rate of impotence increases with age. Old age in itself is not a reason for impotence. Many people have been reported to have regular intercourse in their eighties and nineties. In the Kinsey series itself, 45% of men aged 75 were potent. Disabling diseases explain only part of the cases. It seems that the main reasons of impotence in age are lack of sexual partners on the one hand and loss of self-confidence on the other. The general belief that sex is for the young contributes a lot to the development of the problem. A lot of old people who do not even try to have intercourse have a morning erection or even masturbate regularly. We should add „Burn Out“ as a reason for impotence.

Among the main methods of treatment, hypnotherapy as a method of treatment in secondary impotence is well-established. (Kroger, 1976, Crasilneck, 1979, Beigel, 1980) In this paper we present a modified hypnotherapy technique based on relaxation and indirect suggestion as described and verbalized by Erickson (1979). According to our experience this technique is brief (1-4 sessions) and yields a high success rate.

## Materials and methods

During the period 1976-1986 a total of 390 male patients were referred to our clinic with a presumed diagnosis of psychogenic impotence. At the first meeting a brief sexual and medical history was taken and blood samples were drawn for determining the levels of the following hormones: FSH, LH, Testosterone, Prolactin, thyroid functions. Nocturnal Penile Tumescene (NPT) was performed in several cases where organic contribution was suspected. Patients with any medical pathology including abnormal hormonal levels which might explain the complaint of impotence were excluded.

At the same first meeting some information about the nature of medical hypnosis was

supplied and any question or problem raised was answered. The method of treatment was hypnotherapy lasting 1-4 sessions (45 minutes each) with indirect suggestions according to Milton Erickson (1979) verbalization. To demonstrate the method we shall present an illustrative case.

B.D., 32 years old, unmarried building painter, complained of anxiety state and impotence. He explained his situation as „being afraid of falling off the ladder“. Upon history: it started 6 months earlier after a party where he had consumed large quantities of alcoholic beverages. The same night he tried unsuccessfully to have sex with his steady girl-friend. Several attempts that night failed. (As Shakespeare wrote in Macbeth, alcohol „provokes the desire, but it takes away the performance“.) Next morning he stayed at home because of a severe hangover and depression. Other attempts to perform sexually failed (no erection appeared whatsoever). For two more days he did not leave home and tried desperately to achieve an erection by mutual stimulation with his partner, but in vain. Upon returning to work he found himself in a state of panic when he tried to climb a ladder, and as he expressed himself: „I was afraid I would fail and fall down“. Since then he has never obtained an erection except sometimes early in the morning. Because of his anxiety of falling from a ladder he quit working and has remained unemployed.

Therapy technique: induction was achieved by arm levitation technique, and this for the simple reason that arm levitation is a symbolic expression of an elevated and erected organ. Then we started with verbalization, as suggested by Erickson (1979): „When you were a little child at the age of one year, you knew you couldn't stand up (indirect statement of impotence) ... (pause). And now you know you can't (challenge), try it! You can't ... (pause). And now you truly know how an idea can take possession of you ... (long pause). And now I would like you to enjoy an experience. One or the other or both of your hands will lift up towards your face. (Long pause). And no matter how hard you try to press down, it is going to lift up toward your face. And you can't stop it ... (pause). There is nothing you can do to stop it ... A little bit higher ... There is nothing you can do to stop your hand from feeling hair, the feeling of hair and feeling of warm body ... (pause) And you can't stop your hand from doing that ... (pause) And now you know that whenever you wish, your penis can stand up and feel hair. (pause) And you can enjoy it ... (pause) It won't be your hair. It will be that feeling of her. And you can't lower your hand until you have enjoyed sensing the feeling of hair, sensing a warm body. (pause) And nothing can tell you that your penis won't stand up. Nothing can tell you that. And nothing can prevent it from feeling hair and a vagina for as long as you want. (Long pause). And I want you to have the surprise of your life because sometime today or tomorrow, your hand will touch the hair on her head, and you'll find what your penis will insist on doing. (pause). And you





the hair on her head, and you'll find what your penis will insist on doing. (Pause). And you are going to let that be a surprise. And I would like to tell you that sometime in your lifetime you are going to lose your erection ... (pause). And what you don't know, that this is a sign that your conscious is telling you that the beauty of your wife's body is overwhelming. Enjoy this fact because that is the greatest possible compliment you can both receive ... (pause). And then think of your elevated arm, that nobody can prevent you from lifting it up toward your face, and you will immediately experience the feeling that your penis is elevating like your stiff arm."

After this single therapeutic session, the patient reported that successful intercourse had taken place 3 days later. He was treated with an additional session to reinforce the results. The follow-up was over a year and there were no relapses.

## Results

Cure was defined as the ability to perform sexual intercourse upon wish, with no recurrence of impotence for at least one year. Patients were considered as improved when a successful intercourse was achieved at least once but not always. Failure was labeled when no improvement occurred or when patients dropped from treatment before completion.

Of the 390 patients, 13 were found to have abnormal levels of any the hormones mentioned above. They were excluded from this study and were referred to our endocrinological unit for further evaluation and treatment. Of the remaining 377 patients, 366 had secondary impotence and 11 had primary impotence. Age of the patients ranged from 20 to 65 years.

| Age | No. | Sessions (mean) | Recovery | Improvement | Failure |
|---|---|---|---|---|---|
| 21-30 | 71 | 3.39 | 69 | 1 | 1 |
| 31-40 | 134 | 3.98 | 129 | | 5 |
| 41-50 | 97 | 4.06 | 90 | 1 | 6 |
| 51-60 | 58 | 3.86 | 56 | 1 | 1 |
| 61+ | 6 | 5.40 | 2 | 2 | 2 |

*Table 1. Secondary impotence*

| Age | No. | Sessions (mean) | Recovery | Improvement | Failure |
|---|---|---|---|---|---|
| 21-30 | 7 | 4.1 | 5 | 1 | 1 |
| 31-40 | 2 | 4.0 | - | - | 2 |
| 41+ | 2 | 5.0 | - | - | 2 |

*Table 2. Primary impotence*

Table 1 shows the data concerning the length of treatment and results for the secondary impotence group. Most patients were between the ages of 30-50 years. The average number of sessions was 3 for those 20-30 years of age, and 4 for the next 3 decades up to 60 years of age. For those patients aged over 60 years the length of treatment increased markedly to 6 sessions. The cure rate was high, over 90% for all groups of patients except those over 60 years. For this group only 33% of the patients recovered.

For the primary impotence group the duration treatment was on the average longer and the cure rate was much lower except for the very young ones (20-25 years of age). Although the number of patients was much smaller in this group as compared with the secondary impotence group, it seems that for these patients hypnotherapy may not be the treatment of choice, probably because the primary problem is deeper and a more thorough psychological (insight) therapy is needed. Most patients regained their potency after 1-4 sessions.

## Discussion

Most cases of impotence have an emotional and psychological background. Therefore, psychotherapy of any kind should be the treatment of choice after ruling out the possibility of organic disturbance (Virag, 1984).

The psychodynamics of secondary impotence consists of two main elements. The first is deep trauma in childhood which affected the psychosexual structure of the patient. This trauma can be repressed over a long period of time leaving the patient with an adequate sexual function for years. At a certain point, mainly as a result of another trauma which can be of various kinds, either physical, such as myocardial infarction, road accident, etc., or emotional, such as crisis in family life, failure at work and even an accidental failure in sexual performance.

The first deep trauma and its effect on personality structure reveals itself either consciously or unconsciously. The patient enters into a situation of stress, anxiety and lack of self-confidence, expressed as impotence. The sexual failure itself (sometimes even a solitary event) increases anxiety, stress and fear and creates a vicious circle. It is quite common initially to note sporadic failures which in time become more and more frequent until complete impotence ensues. At this stage the patient discards the task of being an emotional participant in his own sexual act and turns to being a „spectator“, thus intensifying even more the dissociation between positive emotions necessary for normal satisfying sexual relations and the physiological sexual act. Sexual impotence projects itself over other areas of life, such as family relationship, social life and decreased performance at work, studies, etc.



Many methods of psychological treatment have been described. Basically they can be divided into two groups:

a) Radical reconstruction insight therapy with the purpose of solving the deep conflicts and changing the entire psychosexual structure of the patient. The classic form of these methods is psychoanalysis as presented in the basic works of Freud (1979) and Stekel (1965).

Although this approach seems to be logical, it is gradually being abandoned. During treatment many other relevant conflicts are brought to light and these should be solved. As a consequence the treatment is long lasting, (sometimes years), expensive and not always effective (O'Connor and Stern,1972). Comparative evaluation of the effectiveness of the various methods of treatment of secondary impotence finds that psychoanalysis and deep psychotherapy produce a cure rate of 57% (O'Connor and Stern, 1972).

b) Rapid symptomatic treatment trying to overcome the present problem without dealing with the deep and underlying factors. These methods do not intend to change the entire psychosexual structure of the individual, but only to restore the adequate sexual function as it was before the development of impotence.

The brief conjoint behavioral approach is very popular at the present time. An example of this approach is the "sensate focus" technique described by Masters and Johnson (1970). The technique is based on modification of sexual behavior, turning the bedroom atmosphere into a relaxed, supportive and undemanding one. The physiological symptom of impotence, namely the inability to achieve erection, is not treated at all because it is regarded merely as a by-product of the psychological disturbance. Moreover, no one can achieve an erection intentionally so it cannot be taught. Helen S. Kaplan (1974) uses a similar behavior modification technique, but integrates it with short-term psychotherapy and sometimes also with hormonal treatment intended to increase the male libido. Despite the limited goal of this technique, its success rate is quite satisfying, achieving about 80%.

However, these techniques have some disadvantages. The major one is the need of a cooperative sexual partner who takes an active and prominent role in the treatment. Many patients do not have such a partner. Surrogate partners are used in some clinics to overcome this shortcoming but this creates grave moral problems. The duration of the treatment lasts weeks and is quite expensive.

Hypnosis as an effective therapeutic tool in secondary impotence has been known for a long time (Alexander, 1974; Fabri, 1975; Deabler, 1975; Jacks, 1975; Crasilneck, 1979; Gilmore, 1987; Araoz, 1982). However, its use is limited mainly because most sex therapists are not familiar with the technique.

Hypnotherapy has the following advantages over other methods of treatment:

(a) Deep relaxation of the body and mind, cognitive control is quickly achieved both during sessions and at home (by teaching the patient autohypnosis; (b) adequate suggestions are given to strengthen self-confidence and potency feelings in the patient; (c) inhibitions and resistances are easily overcome; (d) whenever necessary, psychotherapy can be used during the hypnotic trance; (e) only the patient himself is treated and the participation of the partner is not required; (f) duration of treatment is short and can be accomplished in separate sessions while the patient can stay in his natural environment.

The therapy of impotence represents a crisis intervention and should be regarded as an emergency case and thus be cured in a short time to prevent separation of the couple and fixation of the symptom.

Our method is different from the usual hypnotherapy technique in using indirect suggestions as described by Milton Erickson (1979). Those suggestions are preferable as they aim directly towards the patient's subconsciousness.

These suggestions are accepted much more quickly and more readily, and incite less anxiety and resistance.

Having used the usual hypnotic mehtods for more than 30 years in our clinic, on changing to the new technique we were surprised by its effectiveness. We recommend every sex therapist who is acquainted with hypnosis to try this technique.

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