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Review Article

Three Techniques of Neurolinguistic Programming in Therapy of Anxious Sexual Failure Expectation Syndrome

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Abstract

Anxious sexual failure expectation syndrome (ASFES) is one of the most frequently diagnosed and universal sexopathological syndromes in males, who seek sexological advice. It was examined in detail in the second half of 1980s – beginning of 1990s. The western literature names ASFES "fear of sexual failure"; it is also termed as "performance anxiety". ASFES belongs to codes F40.1 and F42 in ICD-10, and to codes 6B04 and 6B20 in ICD-11. Anxiety / fear of inability to perform a sexual intercourse or of an impairment in the ability for its proper performance are essentials of this syndrome. These are maximally expressed in the situation of intimacy that, as a rule, results in an impairment of sexual functions because of their disautomatization. ASFES can exist in two kinds: in the form of an anxious apprehension of sexual failure, characterized by compulsive thoughts about a possible sexual failure and hypercontrol of penile tension (if the apprehension concerns anticipated erectile disorders), as well as in the form of fear of sexual failure, characterized by a more expressed representativeness of the emotional component and accompanied with considerable autonomic disorders. A high frequency of ASFES and its universal character have resulted in development of different psychotherapeutic techniques for patients with the above pathology as well as in adaptation and use of already available methods for elimination of ASFES. This article presents 3 techniques of neurolinguistic programming (NLP) used by the author for therapy of ASFES. The first technique, which displayed its high effectiveness, was developed by us and called the "technique of correction of behavioural programmes" (TCBP). Its benefits should include: 1) rapid therapeutic effect; 2) short duration of a session (the procedure takes from 5 to 10 minutes, and its therapeutic component proper lasting 3-5 minutes); 3) absence of necessity to create any special conditions (for example, sensory deprivation); 4) possibility to assess severity of the patient's state and prognosticate effectiveness of the used psychotherapeutic interventions; 5) absence of any complications. Its execution involves, in particular, using of the method of anchor (anchoring), which is basic for a number of NLP techniques. TCBP is realized by two stages. The goal of the first stage is to diagnose stability of pathological programmes and reveal the ability to rehabilitate or form normal behavioural sexual stereotypes (generally, it is referred to the precoital period and the coitus itself). Simultaneously, work is done for destruction of the old stereotype and rehabilitation or formation of the new one. At the second stage we assess intensity of the positive changes, which result from performance of the procedure, thereby making it possible to prognosticate the time of appearance of therapeutic results. The article describes the procedure technique in detail. The "compulsion blowout" technique (CBT) (also known in literature as the "obsession explosion" method), approbated and adapted by us, has proved to be good in ASFES cases difficult for treatment. This is an example of the threshold technique (a balloon cannot be filled with air infinitely, because finally it will blow out; a wire cannot be bent and unbent infinitely, because it will break). Such an elimination of ASFES may result from expressed amplification of the inner voice during modelling of the prelude, this voice reflecting anxiety / fear of a possible failure. The article describes on specific examples our use of two variants of CBT: "multiple ratchet method" and "one-time enhancement of submodality" (in this case, audio) that proved to be rather effective. The therapy of psychogenic sexual disorders can also employ the "swish technique", which is characterized as very fruitful and producing a powerful effect. We have modified this technique and used it, in particular, for therapy of ASFES in men. The idea consists in the fact that by way of a certain technology the initial picture on the screen of a male, who is not confident about his sexual abilities, is finally replaced ("swished") with the picture of the same male, who is entirely confident in his potency. This technique is described in detail. Summing up, it should be emphasized that the use of the three above mentioned psychotherapeutic techniques significantly increases effectiveness of treatment of patients with ASFES.

Keywords: anxious sexual failure expectation syndrome; neurolinguistic programming; "technique of correction of behavioural programmes"; "compulsion blowout technique"; "swish technique".

Introduction

Anxious sexual failure expectation syndrome (ASFES) is one of the most frequently diagnosed and universal sexopathological syndromes in males, who seek sexological advice. It was examined in detail in the second half of 1980s – beginning of 1990s [1; 2]. ASFES is known in the western literature as "fear of sexual failure". This is also termed as "performance anxiety". ASFES belongs to codes F40.1 and F42 in ICD-10, and to codes 6B04 and 6B20 in ICD-11. Anxiety / fear of inability to perform a sexual intercourse or of an impairment in the ability for its proper performance are essentials of this syndrome. These are maximally expressed in the situation of intimacy that, as a rule, results in an impairment of sexual functions because of their disautomatization. ASFES can exist in two kinds: in the form of an anxious apprehension of sexual failure, characterized by compulsive thoughts about a possible sexual failure and hypercontrol of penile tension (if the apprehension concerns anticipated erection disorders), as well as in the form of fear of sexual failure, characterized by a more expressed representation of the emotional component of obsession and accompanied with severe autonomic disorders, which have been described by us [3]. A high frequency of ASFES and its universal character have resulted in development of different psychotherapeutic techniques for patients with the above pathology as well as in adaptation and use of already available methods and techniques for elimination of ASFES [4].

Technique of correction of behavioural programmes

We [1; 2; 5] developed a highly effective method of treatment, which should be referred to neurolinguistic programming (NLP). This was called the "technique of correction of behavioural programmes" (TCBP) and was used mainly in males with ASFES. Its benefits should include: 1) rapid therapeutic effect; 2) short duration of a session (the procedure takes from 5 to 10 minutes, and its therapeutic component proper lasting 3-5 minutes); 3) absence of necessity to create any special conditions (for example, sensory deprivation); 4) possibility to assess severity of the patient's state and prognosticate effectiveness of the used psychotherapeutic interventions; 5) absence of any complications. In order to understand the effect of this method we should note that its performance uses the method of anchor, which is basic for a number of NLP techniques. The anchor is a certain stimulus (kinesthetic, audio, visual, etc.), which in the process of psychotherapy is associated with a certain emotional experience. After it has happened the stimulus itself can cause emotional experience linked to it. So, for example, if we ask the patient to recall some emotional experience and the feelings, which are associated with it and appear in a psycho-traumatic situation, while we simultaneously touch his right upper arm, later only one such touching will be able to evoke the above emotional experience and these feelings. This fact to the same extent concerns an effect of touching the left upper arm that before was associated with the feeling of self-confidence, which developed in certain conditions, the latter being reproduced with help of imagination. The process of using of a stimulus is called "anchoring". Alongside with touching a certain part of body (application of a kinesthetic anchor) the following things can serve as the above stimulus: a certain phrase, a change in the tone or volume of voice, some visual stimulus (for example, an expression of someone's face, with whom the person communicates), smell, etc. TCBP is realized by two stages. The goal of the first stage is to diagnose stability of pathological programmes and reveal the ability to rehabilitate or form normal behavioural sexual stereotypes (generally, it is referred to the precoital period and the coitus itself). Simultaneously, work is done for destruction of the old stereotype and rehabilitation or formation of the new one. At the second stage we assess intensity of the positive changes, which result from performance of the procedure, thereby making it possible to prognosticate the time of appearance of therapeutic results. The technology of procedure (both at the first and second stages the patient and the therapist sit or stand opposite each other) is as follows.

Stage one. The physician grasps with his left hand the wrist on the patient's right hand and asks him to imagine an unsuccessful intercourse as clearly as possible. After visualization a suggestion is made that now the image of an unsuccessful intercourse will lose its brightness, later begin to twinkle, and at last disappear completely. At the same time the physician asks the patient not to be passive, but to try retaining the above image to the best of his abilities. Simultaneously it is suggested that the more the patient tries to retain it the less he will succeed, because his organism (memory, psyche, nervous system) does not need this pathological programme and the organism will be getting rid of it. Therefore, the physician concludes, the image of a low-quality or unsuccessful intercourse will be completely erased. Such an order of expected changes in the image (lower brightness → twinkling → disappearance) is supposed on the basis that it is this order which most frequently occurs during performance of the above actions. It should be emphasized that in order not to lose the patient's confidence if the suggestion is not realized, that happens rarely, or is partial we recommend including words such as "…and it may also happen that…" in the suggestion formula. After that we name desirable changes. It is reasonable to follow this principle of construction of suggestions during the whole therapeutic session. When pronouncing the suggestion it is necessary to put the semantic emphasis just on the words following the above introductory phrase. As a rule, the above described suggestions results in the changes, which were promised for the patient, but he tried to resist them retaining the image of a low-quality or even unsuccessful intercourse. Only very seldom the final result consists in twinkling of the faded image or its dullness. After successful elimination of the image we instruct the patient how to recover it. The patient tries to reproduce the erased image three times. Before each of such attempts we make a suggestion that the more persistently he tries to do it the less he will succeed, and it may happen that the image will never appear at all, since the pathological programme is not necessary for his organism. Usually it does occur in reality. Less often the image appears in a significantly duller kind or twinkling of this faded representation is observed. Very rare cases demonstrate complete recovery of its brightness. Then the physician grasps with his right hand the wrist on the patient's left arm and asks him to imagine his last coitus with a woman that had the normal course. Here it may concern coitus both with his present female partner and with another one, if he has never had a full-value intercourse with his present female partner. If brightness of the image, which has appeared, is not sufficient it should be suggestively amplified. We make the same thing in case of an insufficient brightness of visual reproduction of a low-quality or unsuccessful intercourse in the initial period of the first stage. As soon as the patient achieves a good brightness of visual presentation the following suggestions are made. We note that now he will try to get rid of this image, and the more he works for it the less he will succeed, because his organism (memory, psyche, nervous system) needs the normal ("healthy") programme. It is suggested that the image will be persistent,

firm and it may happen that despite the patient's efforts this image will not disappear. An attempt to eliminate the image is made three times. As a rule, in reality the image does not disappear, its brightness either remaining like before or, in rarer cases, slightly decreasing. If full sexual intercourse was observed only with previous partners, and none with the current one, before attempting to eliminate the image, one should imaginatively replace the previous partner with a current one with whom normal sexual intercourse has never occurred. It is advisable to precede the elimination of this new image with several sessions to strengthen the new program ("... the program, like a tree, takes deep roots, strengthens, and becomes robust," etc.). This type of psychotherapy is technically somewhat more difficult than the previous one and requires a greater number of treatment sessions. Even more difficult are the cases, when the patient has never made any full-value coitus during his life or, even more, his sexual practice has only real or even imagined attempts. In these cases we ask the patient to construct a visual image of the full-value intercourse with the woman whom he dates. Like in the previous option, it is not reasonable to commit to elimination of coitus with the normal course at once. This fragile programme, which is in the process of formation, should be first strengthened suggestively during several sessions, and only after that we should try to eliminate the image. The first stage of work in each of the above options finishes with suggestion that on the threshold of and during intimacy the patient will be absolutely calm and and confident in himself. Subsequent suggestions are aimed at programming of coitus with the normal course. We suggest the patient that his intercourses will proceed in the same way like the imagined ones. The procedure is as follows. The physician tells the patient that from now before and during intimacy he will be absolutely calm and confident in his sexual abilities, like it is now in his optic representation. In exactly the same way, individual functional characteristics of the copulatory cycle and the sensations that arise during sexual intercourse are played out.

Stage two aims at determination of effectiveness of the therapeutic procedure and, consequently, a possibility to prognosticate improvement, recovery and their terms. Here we resort to using kinesthetic anchors combined with a request to see a coitus image, which appears now. At first the physician grasps with his left hand the wrist on the patient's right arm and asks him what image of sexual intercourse he sees. Usually, with a good response to therapeutic effects, an image of full sexual intercourse arises. Then the physician grasps simultaneously with his hands the patient's right and left wrists and asks again, what image of sexual intercourse appears now. Very often the patient sees again a good intercourse. In conclusion, the physician grasps the patient's left wrist with his right hand and once again repeats his question. As a rule, the patient answers again that an image of a full-value sexual intimacy has appeared. At this point the therapeutic session is over. It should be emphasized that we can say about specific prognostic favourableness in those cases when complete or expressed realization of suggestive influences is observed. Selection of patients for carrying on this method of treatment should exclude those persons, who experience difficulties with directed visualization of images and plots as a result of different causes. This is revealed as early as in the very beginning of use of TCBP. The characterized way of treatment must not be used in patients with mental deficiency either, who are unable to understand and, consequently, implement the doctor's instructions when carrying out the described psychotherapeutic interventions. It should be noted that our use of TCBP in patients with ASFES revealed its high effectiveness. In conclusion, it should be emphasized that TBCP contains great potential for creative use and can be applied to the treatment of various disorders that require the creation or restoration of normal programs of any behavioral acts. behavioural acts.

"Compulsion blowout" technique

The "compulsion blowout" technique (CBT) (also known in literature as the "obsession explosion" method), approbated and adapted by us, has proved to be good in ASFES cases difficult for treatment [6] and, like TCBP, belongs to the arsenal of therapeutic techniques of NLP [7]. It should be noted that in some cases anxious expectation of sexual failure is rather resistant to psychotherapeutic interventions. Very seldom it is not eliminated even with the absence of sexual dysfunctions. It may be caused, for example, by the presence of the psychasthenic characterological radical, especially when its expression achieves the level of the corresponding personality disorder (psychopathy). Sometimes, as our clinical practice shows, after a sharp weakening of the phobic component of ASFES sexual dysfunction (usually in such cases we are talking about erectile dysfunction) does not disappear, as it is determined by the presence of obsessive hypercontrol of penile tension caused by the persisting expressed ideational component of the examined pathology. So, in cases of an insufficient effectiveness of curability of the patients it is possible to use CBT. This is an example of "the threshold technique where you take a very strong response and enhance it instead of trying to weaken or eliminate it. You enhance it so swiftly and so quickly that in the certain point it crosses the threshold and "bursts". This resembles very much filling of a balloon with air. Until some moment every exhalation breath makes the balloon larger. But if you go on filling the balloon with air, it will eventually it will burst." Inability to bend and unbend a wire infinitely, because it will finally break, is another example [7]. As it is known in the overwhelming number of cases any innovations have their prehistory. In this connection we should mention a so-called technique of flooding from means of the behavioural arsenal, which before was called "implosive therapy". Stampfl, who developed this method, suggested that a multiple presentation of unpleasant scenes should lead to decreasing their "anxiety potential" through extinction (T. G. Stampfl, D. J. Lewis, 1968). He states that the essence of the strategy of implosive therapy consists in the idea to stimulate the patients to face their nightmares and "bring these nightmares to confusion" [8]. Let us provide two examples, when we achieved a therapeutic effect as a result of using CBT in patients with ASFES. In the first case we employed the "multiple ratchet method", in the second one it was "one-time enhancement of submodality" (in this case, audio).

Multiple ratchet method

Male patient G., aged 20. Diagnosis: anxious sexual failure expectation syndrome, selective variant. On presentation he complained that when he established a sexual relationship with a woman, at first he felt fear . At that time it came in upon his mind that "my penis will not erect" again and nothing will be achieved with the woman again, after that he began to control the tension of the penis by sensation ("with the brain") and with the help of the eyes (visually). If his erection was expressed less than by 100%, he started to think: "Why did I live well with my wife, but face problems with other women?", and while attempting to have an intercourse "it (penis) falls down completely".In connection with the presented complaints we carried out intensive psychotherapy that resulted in sharply expressed weakening of the phobic component of ASFES, but hypercontrol of penile tension was preserved to the full extent. Then we decided to employ CBT. We found that penile tension control increases with the increase in the volume of the internal voice that predicts failure during intimacy and is obsessive in nature ("I tried to distract myself, but nothing works"). The talk before the "compulsion blowout" technique was built in the following way: "Every thought in its intensity can exist only up to a certain limit. If this border is crossed, the obsession will disappear". In this connection we provided an example with a balloon, which during its filling with air can enlarge only to a certain limit; when

the latter is achieved the balloon inevitably bursts. We also pointed out that with an amplification of the voice some stage may develop unpleasant sensations. But in order to achieve positive results he must endure (go through) these sensations and not beat a retreat halfway (usually in such cases we provide metaphoric examples from appropriate fairy tales).The session itself was performed in the following way.

Cycle one: "Sit down, hear your inner voice and imagine that it has increased, or imagine what would be if it increased". The patient heard his inner voice and imagined that its volume was continuously increasing. When the voice became louder, it gave rise to appearance and later (up to a possible maximum limit) amplification of tinnitus. Then we suggested to the patient that he should return the previous volume of his inner voice. He managed to do that. But the tinnitus persisted, though it became weaker.

Cycle two. We suggested the sound be amplified again. As a result, it achieved the same intensity like in the first time, but the accompanying tinnitus was weaker. Later we followed the way of amplification of his inner voice. Now it became a bit louder, the tinnitus becoming more intensive (more intensive than during the first cycle). The patient noted that he could not increase the volume of his inner voice any more. Then we suggested again that he should return to the initial level of the voice. Now the tinnitus did not disappear, but decreased its expressiveness down to the level observed in the end of the first cycle.

Cycle three. We made for amplification of the patient's inner voice again. When its intensity achieved the extent, which was during the second cycle, we tried to increase it still more. As a result this intensity achieved a high level. The accompanying tinnitus was as loud as in the second time. Then we returned again to the previous sound of the patient's inner voice, and again a weak tinnitus remained.

Cycle four. When we began to increase the volume of his inner voice for the fourth time, the tinnitus achieved the same level as during the third cycle, but the volume of his inner voice did not. Nevertheless after all the above volume was achieved and later we succeeded in achieving even its larger amplification. The patient pointed out that he heard a very loud voice (!). At that time we suggested that he should hear such a strong sound, which he had never heard before ("fantastically strong, strikingly strong, stupendously strong"). "Ascend the slope of the mountain towards its summit. When you win the summit you will see a shocking sight and pass into another reality, the reality of a healthy person". He already heard such a strong sound, which he had never heard before (!). We asked him to remain at the achieved height during some time. But the patient announced: he felt that he would not be able to remain on that level. Then we suggested that he should return to the initial volume of his inner voice and have a rest. When he did so, the accompanying tinnitus was still present, but it was weaker than in the end of the previous cycle.

Cycle five. After a very short (1-2 minutes) rest (the patient was tired) we suggested that he should mount an decisive attack. Before that we said: "You should mobilize all abilities of your organism, all strength of your fantasy in order to hear such a strong sound, which you have never heard before. Have patience to hear an unbelievably loud sound for passing into another reality, "the reality of a burst balloon" because it is impossible to amplify any sound infinitely much the same as to fill a balloon with air infinitely. Keep being more persistent in trying to hear a still louder and louder sound". The patient pointed out that the tinnitus had become stronger than it was the time before (!). We carried on motivation for "overcoming", which would help him to get to the mountain summit to his health. His inner voice became still stronger (!). We suggested keeping it on the same level ("maybe, the quantity will transform into quality"). But the patient could not increase the intensity of his inner voice any more. Then we suggested that he should return to the previous volume of that voice. In the end of the characterized cycle the patient observed that the tinnitus was absent, but he felt some pressure in the frontal part of his head. Then we suggested that the patient should open his eyes. After 1-2 minutes we asked the patient to imagine himself in the circumstances of intimacy. He pointed out that his inner voice inclined him to hypercontrol less than before. As a result we drew a conclusion that some positive effect was achieved.

Cycle six. We mounted another "assault" with renewed energy. This time the same volume of his inner voice was achieved as in the 5th time, but the tinnitus was weak. Before the above volume was achieved we motivated the patient to mobilize himself completely for amplification of the volume. When we returned to the initial level of sound volume, the patient did not complain of both tinnitus and sensation of pressure in his head. After the end of this cycle we checked the effectiveness of our therapy. The patient pointed out that when he imagined intimacy any hypercontrol of his penile tension was absent as itself, and only making special efforts he began to control his erection. We drew a conclusion about achievement of a good result that was confirmed during sexual encounters. Analyzing this case we should emphasize that even though the volume of our patient's inner voice did achieve the level, which he had never come across in his real life (he heard such a loud sound, which he had never heard before), still during the session he did not feel any a clear breakthrough. However, a positive effect could be predicted based on the patient's responses to follow-up questions asked after the fifth and sixth cycles. This was confirmed by the treatment results, which indicated the patient's recovery. In this connection we should provide the following statement, which explains what happens in such cases. It is emphasized that many people do not observe when they cross the threshold, particularly if the response must become very intensive, before it blows out. However, if one waits a little so that the kinesthetic system had enough time to settle down again, it is possible to find out that no more coercion is present [7].

One-time enhancement of submodality

Male patient T., aged 39. Diagnosis: anxious sexual failure expectation syndrome. Due to a disorder of erection he could not perform a sexual intercourse. He was going to get married. After our intensive psychotherapy the phobic component of ASFES was actually eliminated, but compulsory fixation on the tension of his penis persisted that resulted in cessation of perception of his woman during the prelude. Fixation of attention on his penis was caused by his inner voice, which was doubtful about success of intimacy. The patient himself characterized his problem as follows: "When erection develops, my brain, in a way, is automatically disconnected from the woman and my inner voice seems to ask whether the erection will be stronger or not, and if now I begin to insert my penis will it lose its erection? Sometimes it happens that at first my control over erection is absent and then my penis is inserted, but immediately my inner voice begins to compare sensations from caresses of, suppose, her breasts with sensations caused by my inserted penis. Then an idea that the erection may be lost presents itself, and finally it really happens". We decided to use the compulsion "blowout" technique.

Technique. We suggested that the patient should imagine the preliminary period and hear his inner voice. We pointed out that the above action led to hypercontrol of his penile tension. We asked him to reduce the volume of his inner voice that resulted in decreased fixation on the tension of his penis. At first, however, he did not gain an understanding of our instruction: he struggled to understand how his inner voice could have any volume. Then we followed a different way and began to say (when the patient closed his eyes) that he was in the preliminary period and his inner

voice sounded not clearly, vaguely and remotely. The result was that the patient stopped fixing attention on his penis and concentrated completely on the woman. Then we suggested that he should return the voice to its initial volume. After that we said that the voice volume was increasing. At first the patient failed to follow that instruction. He observed that then his inner voice sounded weaker than during intimacy and weaker than in the initial stage of performance of the described technique. The voice sounded on the brink of disappearance. Then we suggested again that he should hear his inner voice with its usual volume – which he usually heard during the preliminary period. He failed to do it again. Then we said that we would wait until it happened and it was not his voice that should control him, but he himself should control his voice. Later the patient heard his inner voice with its usual volume. Then we suggested that he should increase it. However he failed to do that. Then we aimed him to imagine that his inner voice sounded louder, and this step made it possible to amplify the voice. The patient imagined that his inner voice sounded stronger, and it increased his control of penile tension. Then we asked him to imagine that the voice sounded still louder (in order to make the performance of this instruction easy for him we described a rheostat, with whose help the light in the cinema/theatre hall becomes still brighter and brighter after the end of showing/performance). To prevent or reduce the patient's escape from inner reality during the technique, we asked them to signal with the index finger of their right hand that the volume of their inner voice was increasing (raising this finger when the volume reached its maximum). The client followed this instruction. After the end of the technique performance the patient said that alongside with amplification of the voice volume he felt that different unpleasant sensations in his organism became stronger, but when he achieved the upper volume threshold, both his inner voice and all unpleasant sensations that accompanied its amplification disappeared. Then we asked the patient in detail what happened to him during amplification of the voice volume. His answer was as follows: “The voice was strengthening. There was some pressure in the upper part of my head, unpleasant sensations in the region of my throat, and contraction of my cheek muscles. Then a moment of something like a physical relief came, and later the voice (its sound) was gone at once”. Making more specific what he felt during his crossing of the “threshold” the patient noted: “When I crossed the barrier, the voice disappeared, I felt a kind of emptiness”. Then we checked the effectiveness of our therapy. With this purpose we suggested that the patient should imagine himself in the situation of intimacy. But he failed to do it and did not hear his inner voice. Then we asked him to imagine caresses and kisses. Now he succeeded, but he never managed to hear his inner voice. Though before, during imagination of intimacy, he had always heard his inner voice, which reflected his lack of self-confidence. Then once again we asked the patient to imagine himself in intimate circumstances, but the voice did not sound again. We drew a conclusion about a good therapeutic effect. One month after the described therapeutic session we communicated with the patient by telephone. He said that after the performed session his sexual function was completely normalized (he regularly had sexual relations with the woman whom he married after the end of our treatment). In this case, unlike the previous one, during our performance of the characterized technique the patient felt absolutely clearly, when he crossed the “threshold” and entered a new reality – the reality of a healthy person (“…a moment of something like a physical relief came, and later the voice was gone at once”).Therefore the provided examples of using CBT demonstrate its high effectiveness in treatment of therapeutically resistant forms of ASFES.

Swish technique

The therapy of psychogenic sexual disorders can also employ the sway method from the arsenal of NLP. This procedure is regarded to be rather effective. Richard Bandler [9] characterizes this technique as very fruitful and producing a powerful effect. According to him, this technique programs the brain to move in a new direction. We have modified this technique and used it, in particular, for therapy of ASFES in males [10]. The procedure of its performance is as follows:

1. At first we ask the patient to recall or imagine some man, who has hundred-percent sexual potency and is entirely confident about his sexual abilities.

2. After that we ask the patient to close his eyes and imagine a picture on the screen, when he is in the preliminary period of intimacy, but with obsessive thoughts that he will not be able to perform coitus. The picture should be bright, contrast and sharp. If it is not so and the picture is dull, we say that there is a booth operator here, who works for a good image on the screen (good brightness, contrast, sharpness).

3. When it has been achieved, we ask the patient to see at this picture a dark spot somewhere on his body. After he has seen it we say that this is a mouth of the bottle, at whose bottom there is a sharply reduced in size, highly potent man confident about his sexual abilities. Then the image of this man begins to enlarge and gradually occupies 1/8, 1/4, 1/3, 1/2 of the bottle. Further enlargement of this image is accompanied with the following instruction: “Now you begin to see that his arms become similar to your arms, his legs become similar to your legs, his body becomes similar to your body, and his face becomes similar to your face”.

4. In accordance with our instruction, the continuing enlargement of the above image (up to 3/4 of the bottle and more) results in the fact that the patient already sees himself, but preserves absolute inner confidence about his potency and sexual abilities present in the model male. In this state the formed image achieves the bottle mouth.

5. Having achieved the mouth of bottle, this image washes off the previous image of a lacking self-confidence patient, who is in the circumstances of intimacy, from the screen. If this picture is not bright, contrast and clear, we work for making it high-quality with help of the “booth operator”, though usually it is like this from the very beginning. Then by counting to 5 we achieve strengthening and fixation of this healthy programme of sexual functioning. Usually the “sway” is carried out 5 times.

Conclusion

ASFES is the most universal sexopathological syndrome in males. There are a great number of psychotherapeutic methods and techniques for its elimination. The three techniques, presented in the article, include the one developed by us, and belong to NLP; these increase effectiveness of treatment of patients with the above pathology and can be used for curing ASFES cases, which are difficult to treat.

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