Sexual Hypnotherapy for the Couples and Family Counselor

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Abstract

This article presents the utilization of Ericksonian hypnotic techniques in conjunction with cognitive behavioral techniques collectively labeled the New Hypnosis, as they apply to the treatment of male and female sexual dysfunction within a counseling setting. The basic principles of the New Hypnosis, as they apply to sexual dysfunction, include processing of internal states of "perceived realities", "in vitro re-experiencing" of the sexual problem, "inward directedness" of the client by the counselor via careful observation and feedback of the client's /couple's psychosematics and somatopsychic expressions, as well as the presence of both members of the couple in the session whenever possible. Subjective biofeedback, activation of personality parts, and mental rehearsal are techniques reviewed as they apply to sexual identity, orientation, preference, role and functioning. Specific techniques to improve functioning throughout the five stages of sexual response (desire, arousal, foreplay, orgasm and processing) are presented. The 'New Hypnosis' is an effective means of helping clients develop new insights into their sexual functioning and overcome debilitating or limiting sexual dysfunctions.

Sex therapy has been defined as "any systematic attempt by a health professional to alleviate sexual dysfunction or difficulties experienced by a specified client." (Wiederman, 1998, p. 88) While early methods of sex therapy were informed by psychoanalytic and psychodynamic conceptual modalities (Rosen & Weinstein, 1988), contemporary sex therapy practice tends to be integrative in nature (Weiderman, 1988). Thus, psychoanalytic and behavioral (e.g., Kaplan, 1974), behavioral and psychoeducational (Masters & Johnson, 1970), systemic (e.g., Leiblum & Rosen, 1991), and medical interventions (e.g., Schover & Leiblum, 1994) are often combined to treat the sexual problems that are presented to a couples counselor. This manuscript will describe a method of conducting therapy that combines elements of Ericksonian

hypnotherapy (e.g., Erickson, Rossi, & Rossi, 1976) with cognitive-behavioral techniques (e.g., Bandura, 1969; Ellis, 1962) which has been used to treat sexual problems in couples counseling (e.g., Burte & Araoz, 1993). Collectively, this integrative method of counseling has been referred to as "The New Hypnosis" (NH) (e.g., Araoz, 1983, 1995, 1998). More specifically, in this manuscript, the basic premises underlying NH, the method of assessing a client's appropriateness for NH, the range of the sexual problems to which NH has been applied, and the principle intervention techniques that have been employed in sex therapy using NH will be addressed.

The New Hypnosis Basic Premises

There are several underlying premises that inform the work of the couples counselor using NH. They are as follows:

(1) The principle focus of the NH is the client's internal process. Since humans experience what is happening in ways that are unique and idiosyncratic to each individual, an individual's perceptions, influenced by his or her personal beliefs, create and change his or her perception of outward reality. Thus, what a person has accepted as being real in his or her imagination is interpreted as being "real" to the client. According to NH founder, Daniel Araoz (1988), "It is not merely the things that happen to us which make up our existence but the things which we "happen to ourselves" in our imagination." (p. xviii) Because there are differences between objective and subjective reality, a client's internal, subjective mode of experience is considered to be hypnotic (Araoz, 1983, 1995). Therefore, the NH assumes that every person uses hypnosis.

(2) There is no need to make the unconscious conscious as is done in psychodynamic, insight-oriented therapy (e.g., Erickson, 1980; Rosen & Weinstein, 1988). Instead, the NH counselor first directs the client to have a full in-vitro "re-experiencing" of the problem. After that mental image has been captured, the client is helped to make it vivid and absorbing by the involvement of as many senses as possible (i.e., besides a mind's eye, we believe that there is also a mind's nose, a mind's ear, etc). During this step, the client is also encouraged to become aware of all the emotions elicited by that situation. In carrying out each step, it is essential that the counselor not hurry this process.

    Thus, instead of the counselor interpreting what a client's responses might mean, the counselor utilizes them to help get the client in touch with his or her inner experience. Asking the client to experience them several times or to connect them with memories, images or body sensations may further enhance their experience. For example, if something happens in the client's life that 'drives him or her crazy', the client is directed to focus his or her attention inside and to monitor how his or her body changes when he or she is being driven crazy.

(3) Next, he or she may be directed to imagine how the reaction could be less negative and "to live" this out frame-by-frame in his or her mind, thus rehearsing what she can experience in the outside world should this happen again. It should be noted that these are not intellectual questions, but are, instead, invitations for the client to get more deeply focused into his or her own subjective experience. NH usually does not use

prefabricated trance inductions. To start the hypnotic work, the counselor listens carefully to what the client says and does unconsciously in the course of the conversation. These unconscious "elements" include the client's choice of words, intonations, and spontaneous gestures, among many other behaviors. Using any one of these unconscious behaviors, the client is invited to have a "moment of mindful detachment from logic and reason" before internally re-experiencing his or her problem.

(4) In his review of theories of sex therapy, Wiederman (1998) concluded that the individual is the primary focus of most therapeutic interventions. While this may be true, we prefer that, when used to treat sexual problems, NH be used with both spouses present. This is because while during hypnosis the couple does not typically interact, after hypnosis spouses usually find much to talk about. It is our hope that this sharing will increase the degree of closeness and intimacy between the spouses. Furthermore, it can ultimately be useful to understand the role that a sexual problem has in the family system (e.g., Arentewicz & Schmidt, 1983; Heiman, 1986; Leiblum & Rosen, 1991; Verhilst & Heiman, 1979; Weeks & Hof, 1987; Woody, 1989).

Determining a Client's Appropriateness for NH

Before deciding on an appropriate therapeutic intervention, it is important to determine if a client is an appropriate candidate for NH. In order to accomplish this, the client is assessed by addressing the following three dimensions: (a) the client must not be psychotic; (b) the problem must be psychogenic in nature (having social or psychological causality); and (c) the client's relationship with his or her partner must be healthy -- having respect, mutuality, trust and commitment.

The assessment along the aforementioned dimensions is accomplished by exploring the client's behaviors and negative self-statements before, during, and after the occurrence of the problem (sexual dysfunction). Of particular interest to the counselor is the type of self-talk that elicits negative mental images. Araoz (1983) has referred to this pattern of thought and mental imagery as "negative self-hypnosis" because it consists of hypnotic-like suggestions affecting mood and behavior. If it is determined that the client is psychotic, has a medical condition that causes the sexual problem or is not invested in a respectful relationship, the counselor will refrain from employing hypnotherapy.

If a client is deemed to be an appropriate candidate for NH, the counselor can begin to make therapeutic interventions. Thus, for a client who acknowledges that he or she gets "discouraged and thinks that he or she will never be able to respond to sex as before," the counselor may proceed to make him or her aware of the negative mental images his or her thinking elicits. This will set the stage for the internal focus of attention that enhances a hypnotic state of mind. Next, the counselor may ask the client to think of a more positive scenario of "what could happen if he or she did not have the problem that was brought to therapy." In this way, the costs and gains of the client's retaining his or her sexual dysfunction can be thoroughly considered. This type of interaction initiates the "induction" used in NH. No formal induction as it is traditionally viewed is utilized. In addition, there is no focus on the "trance depth" of the individual, as it is the internally directed awareness which provides the active component in NH intervention.

Basic Techniques of NH

To further illustrate the experiential nature of NH, three basic techniques will be described from among the many that are employed in this work. They are as follows: subjective biofeedback, the activation of personality parts, and mental rehearsal.

Subjective biofeedback

A client is typically directed by the counselor to focus on how his or her body is responding and reacting to what is in his or her mind. Questions asked may include: "Where in your body is that feeling now?" "What shape, size, consistency, does it seem to have?" "Can it slightly move in your body or change its shape, size, consistency, etc.?" Each time a question is posed, the client is given plenty of time to get in touch with her or his inner experience. The counselor employing NH views all client responses as potentially beneficial. Therefore, while the response of the client may appear to be negative (e.g., "It burns" or "I can't get in touch with it"), it can invariably lead to the next therapeutic directive by the counselor. Thus, if the client says "It burns", the counselor may lead the client into a more multi-sensory experience of the burning as well as a psycho-semantic understanding. For example, to be burned can have a physical meaning or a figurative meaning (e.g., to be rejected or to be taken advantage of). Alternately, the counselor may eventually direct him or her to have an opposite image of a diminishing fire or of their extinguishing the burning. If the client cannot "get in touch with it", the counselor may direct him or her to have an experience of this inability, emptiness, darkness, or helplessness.

Activation of Personality Parts

This technique helps the client own different aspects of his or her personality (Assagioli, 1965). These personality "parts" may be given names, such as, the lazy one, the diligent one, the child, the adult, the daring one, or the fearful one. Thus, if a client proclaims, "I can't do this", the counselor may direct him or her to get in touch with the personality part from which this belief comes, to visualize that part (describing such traits as its appearance, age, etc.), and to become that part now. Next, the client may be asked to listen to what this part is saying. Once this message has been heard, the client may be invited to connect with some other part in him or her that might not accept fully what the first part stated. The two sides are contrasted (e.g., visually, as two screens) and the client is invited to choose which one he or she wants to be in control of the current issue. This technique is used again and again to solidify the healthy choices that the person can make to improve her or his life.

Mental Rehearsal

Mental rehearsal is a "cognitive/experiential method (used) to prepare …(the client) for future situations." (Araoz, 1988, p. 22) In NH application, it consists of the projection of a client's healthy personality parts into the near future. Like in a vivid daydream, the client is guided to be fully involved in doing what he or she "knows is right for her or him." In order for this experience to become a uniquely powerful, personal experience, the client is directed to be aware of his or her reactions in as many inner senses as possible. The counselor must give the client a sufficient amount of time to get into this mind activity. Additionally, the rehearsal is enhanced with the inclusion of a wealth of details; including the directive that the client feel good about it, be proud of

what he or she is doing, while knowing that this is truly what he or she wants to do and be like.

The Range of Sexual Problems Treated

The range of sexual problems treated that may be seen by the couple's counselor may be understood by utilizing a model developed by Seligman (1995). Within it, one's sexuality can be understood by an examination of five categories: identity, orientation, preference, role and functioning.

Sexual identity

At the core of human sexuality lies one's identity as a sexual being. This is the most primitive area of human sexuality; the conviction of gender since early childhood. Some clients may have genuine doubts about their sexual identity or may claim that their body and mind are in conflict regarding their gender (Benjamin, 1966). In these cases, a counselor can perform an invaluable service by encouraging the client to obtain more information pertaining to sexual identity, possibly encouraging him or her to join a serious group of people in the same predicament. If the client realizes that he or she is the victim of one of nature's mistakes, the effective solution is sex-change surgery (Fausto-Sterling, 1985; Green & Fleming, 1990; Money & Wideking, 1980). Needless to say, this type of client needs much support and encouragement from the counselor while preparing for this very drastic step.

Sexual Orientation

In these cases a client is confused about his or her spontaneous attraction people for those of the same sex. To believe in choice when it comes to sexual orientation is contrary to what has been learned about the importance of biological factors in sexual orientation (Bell, Weinberg & Hammersmith, 1981;Hamer, 1993; Pool, 1993; LeVay, 1993;Money & Schwartz, 1977). In these circumstances, through the combination of supportive and psychoeducational counseling, the counselor can help a client "accept what cannot be changed." This position is contrary to that espoused by "conversion therapy" proponents (e.g., Throckmorton, 1998).

Sexual Preference

This category refers to the "things" (behaviors, objects, sounds, scents, physical sensations or emotional situations, specific parts of the human anatomy and much, much more) that elicit sexual interest, desire and arousal. Because preferences are highly subjective, and are often culturally framed, a counselor may find him or herself in situation in which clients will welcome the right information or the necessary reassurance thereby normalizing a couple's sexual taste.

Sexual Role

Sex roles pertain to the expectations of each one of us just because we are male or female. These expectations come from our socio-cultural groups (e.g., economic, ethnic, family, religious) as well as our time in history and geographical place on the planet.

These and other factors affect the expectations that we have for ourselves and others because of our sex. Most couples counselors will be confronted with clients who present problems relating to sexual role rebellion at some point. Such cases may range from clients wishing to express their non-conformity in dress or makeup to established transvestism. In such instances, we believe that the same principles that proclaim that it is the counselor's ethical responsibility to actively intervene to fight racial and ethnic discrimination in a client's social environment (e.g., Atkinson, Thompson, and Grant, 1993) should apply to those counselors whose clients' have sex roles that are different than those of the dominant culture. If the counselor is not well read on this aspect of human sexuality, he or she may help perpetuate the prevalent sex role cultural biases and stereotypical expectations.

Sexual functioning

While clients may be experiencing problems in any of the aforementioned categories of sexuality, NH interventions have been applied more specifically to problems of sexual functioning. In his synthesis of the contributions of Masters and Johnson (1966) and Kaplan (1979), Araoz (1988, 1998) observed that five progressive stages were most likely to effect sexual functioning: desire, arousal, foreplay, orgasm and processing. Problems relating to sexual functioning are the category of problem that our clients have presented in therapy, and NH interventions that have been used to treat them will be covered in more detail in the following pages.

Applying NH Techniques To Treat Specific Sexual Dysfunction

In order to accommodate to space limitations, we have organized a description of these techniques following the five stages of sexual response (Kaplan, 1974). Many of these techniques of sex hypnotherapy are described in greater detail elsewhere (Seegel & Araoz, 1987; Burte & Araoz, 1993; Araoz, 1998).

Sexual Desire Stage

This first stage of sexual response comprises both interest in sex and the desire to experience it. The two extremes of this dimension are an inhibited sexual desire (ISD) and its opposite, excessive sexual desire (ESD). Lack of interest and curiosity in sexual matters make up ISD, while excessive, even compulsive, sexual interest, desire and activity (e.g., satyriasis or nymphomania) fall under ESD.

In the case of ISD, the client may be asked to re-live in his or her mind past positive sexual experiences. The emphasis is on "owning" these as belonging to him/ or her. This revivification experience is practiced more than one time in the office and is prescribed as a home task. There have been, however, cases where a client cannot recall any positive or exciting sexual experience from his or her past. In these instances, he or she may be asked to mentally rehearse what it would be like and to see him or herself with their partner sharing this sexual experience. In most cases, the motivation of an ISD client for seeking therapy comes from their partner or from their being in a new relationship which has reached the time for sexual activity. We have found it useful to ask these clients to imagine themselves making love (or merely having sex) with their partner. If there are no serious problems with accepting sex with the partner, this mind exercise is prescribed as a home task. Conversely, if the client cannot imagine him or

herself in a positive and joyful sexual situation, they may be asked to think of someone that they know or a literature or movie character whom they considered very sexy. Once identified, the client is guided to imagine him or herself watching this person in a sexual situation. This distancing or dissociative method can prepare the client to imagine him or herself having enjoyable sexual relation.

There are times when we have found it helpful to apply a hypno-behavioral technique described by Kroger & Fezler (1976) in which the client is directed to list those sexual activities experienced during the whole sexual encounter that they found to have been more acceptable than others (specific forms of touching, particular scents, etc,). These are then used more emphatically in the mental rehearsal.

When the problem is ESD, one useful NH technique is to imagine how it is experienced inside of one's body or one's life (e.g., what it looks, feels, sounds like). To more fully capture its presence, a client may be invited to compare the ESD desire to something that is concrete and familiar (e.g., like a fire). It is important for this comparison to come from the client, not the counselor. Once this metaphor has been discovered, the counselor guides the patient to work with it (the fire can diminish with a heavy rain) as if it were real, and to experience how this change affects him or her.

Another effective technique is the activation of personality parts described earlier. Because clients bring ESD as a problem, the counselor can help them identify both lustful and diffident personality parts. Once this is accomplished, the counselor may guide the client to engage both parts in conversation and to listen to each part before deciding which will be in control of the other. Usually the perceived negative "part" they want to change has been in control of their actions. Now they are put in contact with the other, positively perceived part. Clients are then coached into mentally rehearsing what life will be like under the control of the positively perceived part.

Sexual Arousal Stage

Usually the presenting problem is that the client, even though mentally interested in sex and wanting it, either takes a long time to experience a physical reaction or simply does not have any. The problems of this stage are referred to as vasocongestive disorders (VCD) and include erectile problems for men and lack of lubrication or vaginismus for women. More rare is the opposite problem when a person is sexually aroused by the weakest stimulus. We found that this situation, when psychogenic, is one of a personality disorder.

For all VCD, hypnotic relaxation is important to make sure the client knows how to relax and succeed in doing so. Time should be given to practically teach the person relaxation. Performance anxiety, fear of intimacy, anger and other hidden feelings produce stress. By relaxing, people often start to become aware of these issues. We have found that developing relaxation skills is a precondition for the success of the specific NH techniques used in VCD.

For problems of psychogenic vaginismus, the client has to connect with what she, at the imagination level, "thinks" is going on. Furthermore, she must visualize why this reaction takes place. This is a hypnotic exercise because it is experiential in nature. After accomplishing this, she can discuss it with the counselor in a rational, logical interpretative manner. Then, hypnotically again, she can "talk" to her vagina and ask it to cooperate with her desire to welcome the most intimate visit of her sexual partner. This

must become a conversation, listening to what her vagina responds or to the objections she (it) has against sexual intercourse.

For lack of vaginal lubrication, the experience of salivating at will, by vividly visualizing a fresh, delicious, piece of fruit, that is then tasted and enjoyed slowly is associated with vaginal comfort, relaxation and pleasure, involving lubrication. The main message to be received by this practice is that the mind influences the body and the body follows the mind. Although the process of vaginal lubrication follows a different physiological process than salivation, the mind is able to adapt the concept to the relevant process by focusing on the result rather than the stimulus or pathway. Figuratively, the vagina can learn to "salivate" (lubricate) for the sexual experience.

The "colorizing technique" has helped many couples improve VCD's. When they mentally rehearse the situation without the problem, the counselor, using hypnotic techniques, asks the client to pay attention of the color that predominates in the mental picture. When the patient mentions a color, it is prudent to inquire if it is a good color. If so, the patient lingers on it, visualizing how its hue changes with his/her breathing. Napier (1990) has presented practical means of using this mind exercise for self-therapy. Colors as emotionally influential have been researched in Europe in the 1950's and 60's. In the US, Lucher (1969) is known by his color test of personality. Colorizing, as a hypnotic technique creates a safe and positive environment for the client who later reminds him or herself of what he or she wants to improve by "putting him or herself in the (particular color)."

The same approach may be used when people experience psychogenic pain during sexual intercourse. Following the basic rule that if the symptoms are not from the body they come from the mind, colorizing is a practical technique. The only caveat is that it should be used in conjunction with mental rehearsal. Only when the client believes that he or she can experience, act or do something specific, the predominant color in the mental picture becomes helpful.

In all VCD cases, clients can be taught another dissociative technique consisting of a cartoon-like conversation with one's sexual organs, so that there is cooperation between mind and body. In this technique the client has to pay careful attention to how their body responds because there are often unresolved unconscious issues that need to be taken care of before there is genuine sexual enjoyment.

The Foreplay Stage

The problems presented here are of two main categories, coming either from lack of "education" or from a sense of boredom, lack of emotional excitement and distracting thoughts unrelated to the sexual situation. This seems to be an important aspect of what Seligman (1993) calls acedia. Under the category of lack of education, we have found clients who experience a polarity of thoughts concerning foreplay. Specifically, on the one hand, they believe that foreplay is not for long standing couples or is for youngsters. On the other hand, there are still many men (the number of women is much less) who want to get to sexual intercourse bypassing foreplay as loss of time. They laugh at the idea of gourmet sex. In general, problems at this stage may indicate serious difficulties in the relationship. In these cases, couples counseling is indicated.

Hypnotically, we have found that mental rehearsal is useful to help couples see themselves acting within the paradigm of the two polarities mentioned above. The couple

discusses new possibilities to make their love making more satisfying and exciting for each other. Next, they are guided into the vivid imagination of such possibility. This is their mental rehearsal. Once this brief exercise is finished, they compare notes and discuss concretely what they can change in order to make their sexual experience more meaningful. After this discussion, they are guided into the same mind exercise, this time enriched by the details of what they discussed before. They are told to practice this at home, alone or as a couple, several times in the next few days and to engage in sexual activity only after they start feeling a little more excitement than before. To measure excitement, they are asked to imagine a 10-point scale (10 being the highest score) and to determine individually their current score. It usually is below five for the person suffering from acedia. Only when they can truly believe that the individual score has reached seven or higher should they engage in sexual activity with the partner.

The Orgasm Stage

The inability to reach orgasm in the absence of medical reasons is often (not always) a manifestation of a problem in the relationship that has not been faced. Of course, it may also be lack of sensitivity of the partner to the anorgasmic spouse. We do not accept the self-made diagnosis, although we want to learn what their explanation of the problem is (if they have one). It is often helpful to ask the couple to think for a minute, without saying anything out loud, what images come to mind when they think of reaching orgasm. Typically, this produces a simile, as they metaphorically say something like, " it's like being half dead." If they do not bring up an image spontaneously, it helps to ask them to find a comparison. Thus, they are asked to answer the question, "This is for me like…." This focus on the metaphorical side of thinking prepares them to use hypnosis effectively because, in our view, hypnosis is basically a process of thinking metaphorically. The image used in the metaphor or the simile is then worked on. For example, one woman described her inability to reach orgasm, in spite of being sexually aroused, as "a big obstacle, like a barrier." She then was asked to visualize that barrier in great detail –size, color, appearance, etc.—and to try to modify it or to find a way to overcome the obstacle. Later, discussing the hypnotic experience, she discovered the "meaning" of her mental images realizing there were "areas" in the marriage that needed resolution. One such "area" was a brief affair her husband had had years ago with someone at work. After their images were resolved in counseling, mental rehearsal was employed, in which they vividly imagined themselves enjoying the sexual experience to orgasm.

The Processing (quasi) Stage

Properly speaking, processing is not an independent stage at the end of the sexual encounter but rather a continuous mental activity starting from the desire stage. However, because after sex most people in our culture "evaluate" what happened and even give themselves a "grade," it is important to keep it in mind as a quasi-stage of the human sexual response**.** It is important at this quasi-stage to help couples develop positive self-talk and avoid negative self- evaluations. Utilizing the NH couples can communicate in a non-threatening manner their sensations and images associated with the positive aspects of the experience.

Conclusion

This article has sought to present the counselor with a model for working with individuals and couples who are experiencing sexual dysfunction. Through the use of the New Hypnosis, counselors can help clients explore their dysfunction. The NH seeks to help clients gain understanding of their difficulties throughout a process of inward directedness via the "in vitro" re-experiencing of their "subjective reality".

By utilizing the NH approach for sexual problems, individuals and couples can be brought to states of inner awareness which enable them to change from within their personal or couple schemas. When successful, clients terminate treatment with an increased sense of mastery of their difficulties and renewed feelings of individual and couple empowerment. As the NH is increasingly applied within the counseling setting we hopefully anticipate a furthering and enrichment of its application within the domain of sex therapy,

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