Cognitive Hypnotherapy With Sexual Disorders

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Research has found that in psychogenic sexual disorders, cognitive processes are more important than physiological ones. Negativistic "thinking" about one's sexual activity aggravates the symptom and perpetuates it. Therefore, as vital as a differential diagnosis of sexual dysfunction is, the uncovering of Negative Self-Hypnosis (NSH) becomes essential for the successful resolution of the sexual problem. NSH constitutes the "hidden symptom" in all psychogenic sexual dysfunctions. After explicating NSH, the paper offers specific hypnotic techniques for different sexual disorders.

TRADITIONAL HYPNOSEX THERAPY

Early applications of hypnosis for the treatment of sexual dysfunctions can be seen in the work of Erickson (1935). His indirect imagination techniques focuses the clinical attention upon the symptoms, which were viewed as an expression of some personality problem. Somewhat later, van Pelt (1958) focused his approach upon helping the patients uncover past traumatic events which he believed were producing anxiety and consequent dysfunction. Through direct suggestion of "new ideas" he believed he could eliminate the anxiety producing dysfunction. He reinforced these "ideas" through mental imagery and mental rehearsal. Once again, the focus of the therapy was up on the individual who manifested the symptom.

Beigel (1972) was one of the first hypno-clinicians to incorporate the dysfunctioning individual's partner, engaging him/her as an ad hoc co-therapist. Beigel's primary approach was mental rehearsal (Beigel 1963), with the focus of the therapy being placed upon the symptom and the individual who manifested it Although some authors pointed out the importance of treating the inter-relationship between partners and not only the symptom, in many cases the focus of treatment still consisted of suggestion and directive hypnotherapy (Kroger & Fezler, 1976).

THE NEW HYPNOSEX THERAPY

More recently, two important developments have begun to come to the forefront of hypnotic treatment of sexual dysfunction. The first important change was to place the focus of treatment upon the "hidden symptoms." In so doing, the emphasis of therapy is upon the cognitive functions such as negativistic imagery and self-talk (LoPiccolo ,1980)/

Similarly, Walen (1980) presents her eight links of the sexual cycle, recognizing the close connection between cognition and human sexuality.

The second important development in hypnotic treatment of sexual dysfunction is the focus upon the systemic aspects of the dysfunction. Borrowing from the family systems model, Araoz (1982) focuses upon the cognitive interactive process between partners, examining how one partner or the other may be involuntarily perpetuating the problem. The current article focuses upon those aspects of the "hidden symptoms" that are the cognitive process, discussing their role within both the individual and systems models.

Among the earlier works in defining human and sexual response Masters and Johnson (1966) established the four stages of sexual response. By defining the anatomical and physiological differences between the stages of excitement, plateau, orgasm and resolution, they laid an initial groundwork for future researchers. The primarily directive, educational and behavioristic techniques that followed, however, offered no direction for the cognitive processing pressure on the individual's overt actions, while perhaps actually creating negative self-definitions for the individual.

Walen's (1980) eight-link model, which was to follow, emphasized the cognitive elements in human sexuality. The eight links are (1) perception of the sexual stimulus, (2) evaluation of the stimulus, (3) physiological arousal, (4) perception of the arousal, (5) assessment of the arousal, (6) sexual behavior, (7) perception of that behavior, and (8) evaluation of the sexual behavior. Indeed, it can be seen than many of these links are purely cognitive and hypnotic in nature.

NEGATIVE SELF-HYPNOSIS (NSH)

At any point throughout this process, should the individual generate negative assessments, than a process we refer to as Negative Self-Hypnosis (NSH) is generated. Negative self-hypnosis consists of "the non-conscious negative statements and defeatist mental images that a person indulges in, encourages and often, even works hard at fostering, while at the same time, consciously saying to him/herself that she/he wants to solve the problem, wants to change, wants to get better." (Araoz & Bleck, 1982, p.56).

In fact, our experience with individuals demonstrating sexual dysfunctions suggests that the common denominator and "hidden symptom" is NSH. In general, most cognitive approaches to sex therapy attempt to address overtly the "hidden symptom." Ellis (1962) discusses examining and disputing the patient's "irrational beliefs," Meichenbaum (1973) discusses self-instructional training, replacing negative self-statements with positive self-talk. It is of further importance to note that both these approaches use imagery (rational-emotive imagery in the former and rehearsal in fantasy for the latter).

We believe these processes are better labeled as negative self-hypnosis because they share a number of elements commonly associated with hypnosis. These specifically include: non-critical thinking, active negative imagery, and powerful post-hypnotic suggestions in the form of negative self-affirmations.

As previously stated many of the cognitive approaches rely heavily upon the use of imagery and directive suggestions. Wish (1975) proposed a series of techniques including thought stopping, covert assertion and conditioning and systematic de-sensitization.

Whether in the form of self talk or pictorial imagery, it would appear that these techniques seek to address the "hidden process." By that we mean that the focus is upon what the patients are telling themselves about the problem and what mental representations come to mind.

Through hypnosis the negative processing can be more readily accessed and revivified for examination. In negative processing the individual engages in a continuum starting with (1) stimulus detection or awareness of a sexual situation leading to (2) labeling it, going on to (3) attribution or interpretation of it and ending up in (4) an evaluation. If the processing is mostly negative in nature, dysfunction, or lack of sexual desire are likely to occur.

An example of this would be an individual experiencing premature ejaculation and a lack of sexual desire – problems demonstrated in the following vignette.

A CASE EXAMPLE

As a teenager, the patient determined that his penis was smaller than that of his peers. This was based on observations of his peers while taking showers following physical education class. As a result, the patient assessed that when erect, his penis would be judged inadequate by females with previous experience with other men. In addition, he became highly anxious about any sexual contact that allowed his partner to "assess the size of his penis." He continued to withdraw from sexual opportunities, affirming to himself that he would be unable to satisfy a woman with his "small erect penis." to avoid having to expose his perceived inadequacy and address his "hidden symptom" of negative feelings about his penis size, he developed an overt symptom of premature ejaculation. In this way, he could eliminate his erection before his partner had an opportunity to "assess him." As revealed during hypnosis the overt symptom was less threatening than the "hidden symptom."

The focus of the hypno-therapy was to help the patient understand how he had assessed the stimulus situation as threatening, labeled himself as "too small," developed an interpretation of the situation including a covert dialogue in which he apologized for his overt symptom while covering up his hidden symptom and finally coming to an evaluation in which he was always going to be a failure to women. As each NSH statement and image was examined the patient was helped to reassess his current stimulus situation, which consisted of a supportive albeit frustrated wife, re-label his self-assessment and change his dialogue. It is interesting to note that his wife was well aware of her husband's "size," and was quite content and reported that although she had frequently re-assured him of her comfort with him, he refused to believe her (further demonstrating the non-critical thinking and covert nature of the process).

INDENTIFICATION OF NSH

The preliminary step is to help clients become aware of their negative self-hypnosis. To accomplish this, we often ask the clients to focus in on either the symptom, or the situation surrounding the symptom. In a directed free associated manner the patient is encouraged to focus inward, to allow any thoughts, images or sensations to manifest. Generally, the patients are guided through the examination of their negative self-affirmation, negative imagery, and alterations of their mood. Typically, there is an alteration between the former two and a checking back on the latter as individuals express their "thoughts" and "images." In so doing, the focus is switched away from the symptom to the internal representations the patient is generating.

In certain cases, a focus on the somatic experience is helpful. This helps clients to recreate the sensations they experience during their dysfunction and from there, the therapist can ask clients to express in words how they "feel." Often what is expressed is either metaphors of the symptom, e.g. "I feel like a dark, dry cavern," as in the case of a female patient experiencing vaso-congestive dysfunction; or more generalized, "I feel like a nothing," as expressed by a man with impotence. In such cases individuals are led into the inner experience of their metaphor, and if possible, encouraged to use imagery to create positive visual and verbal affirmations. In the former case, the patient imagined moving through the cave, coming to another entrance which opened onto a waterfall and was filled with mist and moisture. Over time, she was able to visualize the new cave. In the latter case, the individual focused upon his self-talk, addressing the negative self-statement about himself. Interestingly, as he repeated the phrase, "I am nothing" over and over, sub-vocalizing to himself as a way of moving into his negative self-affirmation experience, his psycho-semantics modified slightly and he began to say "I am no thing," then finally an image of himself without a penis came into his mind. He worked on understanding this image of himself and the images focused around the self-talk of being "a dickless wimp," a name he was often called by his father, and which as at the heart of his feelings of inadequacy and self-anger. Through cognitive hypno-therapy, he developed a better understanding about himself and his impotence dissipated.

TECHNIQUES FOR COUNTERING NSH

The hypno-therapeutic interventions to counteract the process of negative self-hypnosis can be divided into general and specific techniques. Three basic principles, however, are common to both. First, do not provide the client with grounds for resistance. The utilization of a permissive invitational approach and careful observation of the client's inner representational modalities help avoid the build-up of resistances. Second, help the client experience, his/her sensuality as joyous, childlike, or playful experience and third, approach the symptom whenever possible from a systemic direction involving the sexual partner in the hypnotic techniques as much as possible.

These basic principles can be applied to the three main uses of hypnosis in sex therapy: 1) etiological understanding, 2) symptom relief and 3) subconscious mental rehearsal. A

range of hypnotic techniques can be used to examine the etiology of the sexual problem including its genesis for the individual and maintenance within the system. Five specific diagnostic techniques have proven especially elegant and effective. The first technique, covert sexual examination, involves having the client while in the alternate state of hypnosis, see him/herself naked in front of a full-sized three-way mirror and to describe his/her body, evaluating every part of it. Questions can be asked, focusing on the client's descriptions and the client can be invited to express associations with past memories of current situations. Couples can engage in this procedure simultaneously sharing their experience of themselves and their partners. Positive affirmations can be introduced by the therapist, but even more effectively by the patient.

Another technique involved utilizing the subconscious wisdom of the individual to allow the real nature of the sexual problem to be revealed to the conscious mind. This can be accomplished through imagery such as visualizing a TV screen, which presents different aspects of the sexual problem, or through the examination of somatic sensations that act as a bridge to underlying conflicts. Having a couple work through an induced dream (Sacerdote, 1967) gives them a common point to explore their respective experiences within the systemic aspects of the sexual problem.

A well-known and frequently utilized diagnostic technique is the use of ideomotor questioning where, while in a hypnotic state, the patient is asked to answer questions either "yes" or "no" by raising one or another finger. The technique is especially useful in "sensitive" areas where the emphasis is on the patients' subconscious response to questions that the conscious mind many not wish to address. In couple counseling, this is especially helpful in creating an atmosphere where the partners feel an increased permission to answer honestly and openly. This is due to the distance created when their sub-conscious is allowed to answer for them.

In the use of hyper-memory, clients are asked to review their life as if watching old movies or slides. The clients are encouraged to focus on feelings and perceptions to gain insights into the relationship between their past and current sexual problems. The presence of the sexual partner can provide support to the client, and gives the partner greater insight into the client and how the couple's role may be interacting with the systemic nature of the problems.

The future-tense technique invites the individual to visualize a double screen, one containing the present with the problem, the other with the problem resolved. The client and/or couple are encouraged to discuss the experience of seeing her/himself or themselves with the problem resolved. Here the focus is upon experiencing the process of change. This technique may be especially helpful in diagnosing the motivation for change and the amount of discouragement the individual or couple may be experiencing. The technique may also lead to the production of encouraging affirmations and perhaps a renewed effort to bring about that change.

Exploratory techniques in sex hypno-therapy provide the therapist with an understanding of the cognitive mediational data (processing) which may be going on conjointly with the

sexual symptom. In one scenario, patients are invited to experience a safe comfortable place where they can allow themselves to explore or learn about their own inner thoughts and beliefs. This is often accomplished by having the patients imagine a void or a device that will allow this material to present itself. Another approach uses the symptom itself as the road back to the subconscious processing. Here the individual or couple are asked to focus on the symptom and become aware of any physical sensations in the body. From there, the couple are invited to focus on these sensations and allow any associations connected to these sensations to arise. The associations are then explored and worked through conjointly or sequentially.

Symptomatic Relief Techniques

Another element in sex hypno-therapy may require directly focusing in on symptomatic relief rather than subconscious reasons and implications. Imagination and suggestion are the key tools in symptomatic techniques. One such approach is Watkins (1978) ego state therapy, where while under hypnosis, the individual imagines the non-symptomatic self-negotiating with or overpowering the symptomatic self. A variation on this would be to have the person visualize the symptoms as something concrete and then work toward their change or disappearance. A third technique may involve asking the individual to visualize and imagine connecting with health forces that are channeled to the sexual organs and their connections to the nervous and muscular systems.

Throughout any of these direct symptomatic techniques the emphasis is upon the experience of the patient or partners from which the cognitive negative self-hypnotic components can be addressed as they arise. To avoid these components, would be tantamount to dismissing the whole person to correct the symptom within a void and most likely prove ineffective.

Symptoms Transference

Transfer symptomatic techniques utilized the phenomenon that individuals can transfer sensations from one part of the body to another. For example, suggestions of relaxation can be transferred from one muscular area to another; muscle rigidity can be metaphorically transformed to erectile rigidity; increased salivation can be transferred to increased vaginal lubrication. It is interesting to not that the physiologically synonymous, but rather symbolically or symptomatically similar, further emphasizing the cognitive mediational process connecting the two experiences. Another approach calls for the creation of an affect bridge. As described by Watkins (1978) the affect bridge allows the individual to connect previous experiences with current symptomology by utilizing the symptom as a path to previously undetermined experiences which now generate negative or disruptive cognitions (NSH). Pelletier's (1979) earlier work encouraged the transfer of qualities of powerful metaphorical images (e.g., a might tree) to ego strengthen the patient. Erickson's (1935) use of metaphor and Hartland's (1975) indirect ego strengthening also rely heavily upon the extended us of metaphorical and symbolic imagery in enhancing the specific behaviors, cognitive self interpretations or non-critical judgments of the symptom to bring about its change or dismissal.

Mental Rehearsal

The use of mental rehearsal popularized by Maltz (1960) and later by Hill (1966) and Barber (1980) has also been applied in the area of sexual functioning (Araoz & Blec, 1982). While the neuro-linguistic programming school of thought might argue about the development or neural pathways leading to new behaviors, a more cognitive bent would suggest the ego-strengthening aspects of seeing oneself as having changed. It has been suggested that these changes help enhance the individual's other modalities of overall functioning, reinforcing the changes (Lazarus, 1977). In addition, the ability to imagine change and visualize oneself in the future, having moved past their present symptoms can help to energize the individual's expectancy, attitude and motivation toward change (Burte & Araoz, 1982).

Teaching clients how to engage in mental rehearsal and utilize it at home can greatly enhance the rate of progress with which the therapy proceeds. It also acts to reinforce the patient's sense of self-mastery, representationally altering the symptom initially, and when utilized with a couple, allowing for the introduction of the partner into the experience. We have found that making tapes of the sessions which the client can take home can also enhance the use of mental rehearsal.

FEMALE SEXUAL DYSFUNCTIONS

Vaso-congestive dysfunction (VSD) refers to inadequate physiological arousal resulting in absent or partial genital vaso-congestion with slight or no lubrication. One technique that is employed, *Dynamic Sexual Imagery*, asks the client to mentally review her progression from her first thoughts of sex through the initial steps of physical closeness and sexual desire. The therapist provides constant positive input lingering on the positive feelings and sensations throughout the process. Monitoring the facial and somatic posturing of the patient, the therapist must be careful to pace the patient and check for intruding negative cognitions and images, which can be either addressed or placed aside as the pleasurable, nurturing, loving imagery is focused more concretely upon her body and the genitalia. "It's so nice to be so relaxed and still be so aroused, my body and mind operating as one, my feelings of warmth flowing throughout my body, lubricating, open and relaxed." Here the focus is again upon the positive imagery and affirmations. Finally, posthypnotic suggestions should relate this exercise to appropriate situations with her partner. Taping the sessions allows the patient to further practice and reinforce the dynamic imagery presented by the therapist at home or with a partner where additional stimulation can augment and reinforce the imagery.

Un-tensing is a technique in which the patient learns to relax the different parts of her body with particular focus on the pelvic area specifically incorporating the genitalia. Including the sexual partner in this approach is especially helpful in that his presence may be a contributing factor in the tenseness of the patient and thus his presence during the un-tensing may help engender a new conditioned response to relaxation. In addition, his

tension may be contributing to the patient's symptoms and together, combined with dynamic imagery, they may develop a more relaxed or playful approach to the symptom.

Although salivation and transudation (the process by which liquid appears on the vaginal walls) are different physiological processes, the experience of the vagina becoming moist is subjectively experienced as similar to salivation by many women. Based upon the subjective analogy an association is developing between the natural process of salivation at food and the natural process of producing vaginal lubrication during sexual arousal. Once again, positive dynamic sexual imagery is incorporated. The partner is encouraged to share the experience of the patient's vaginal lubrication without wishing to copulate. Finally, after affirmation, and when the symptom is reduced, intercourse is recommended.

In the treatment of vaginismus a combination of the exploratory techniques, dynamic visual imagery, and relaxation/un-tensing are quite effective. However, for the highly cognitively subjective experience of vaginismus, it is especially useful to engage the client in her image of the vaginal area (i.e. if the client visualized the area as knotted, then visualize the knot untying). Often symptom relief can be achieved but the psycho-semantics of the patient should be carefully observed for clues to underlining cognitive processes (NSH) that speak to the genesis of the problem.

Pre-orgasmia (arousal but an inability to attain an orgasm) can be addressed utilizing the *body trip technique* in which the patients while in hypnosis is asked to imagine herself inside her vagina and to move about, touch, and sense the areas that provide nice, pleasurable sensations, to vivify these feelings and perhaps to materialize them as a "thing." When she is relaxed and enjoying these sensations, her partner is introduced into the mental imagery and incorporated into the pleasurable sensations by imagined touching or genital contact. Finally, she is encouraged to repeat this procedure with her partner utilizing self-hypnosis. The role of the partner during the sessions can augment his understanding of his role in her fantasy experiences, helping to accomplish the desired goal.

For the conditions of inadequate pleasure, techniques of *symptom manipulation* (Kroger & Fezler, 1976) and *time distortion* may prove helpful. In most cases, however, the exploratory techniques as described earlier my be most effective.

MALE SEXUAL DYSFUNCTION

Male sexual dysfunctions may parallel female dysfunctions in many ways. Dynamic sexual imagery can be incorporated in experiencing erectile difficulties. The patient in initially encouraged in trance to imagine a pleasant non-threatening scene of his choice (e.g. the beach). Extensive vivification of the scene as safe, secluded and relaxing (filling in the details of sun, sounds, smells, etc.) will enable the man to experience the sensations of comfort and security. Once the scene is established a non-threatening female of his choice is introduced (i.e. partner or someone else, previously designated). She may be seen as approaching from a distance. If tension builds up the progress of the "woman" is

stopped. Eventually, as the patient becomes more comfortable, the woman may join him. In imagery, he becomes excited and attains an erection. Over a period of sessions while the patient is in a trance, the scene is repeated until he achieves successful coitus within the imagogic scene. *Post-hypnotic suggestions are used to re-create this fantasy as a given signal while with his partner*. This approach provides a competing positive self-hypnotic image to displace the NSH.

Similar to the analogous approach utilizing salivation for transudation in VCD, *finger catalepsy* can be used and transferred to the penis, utilizing positive suggestions or rigidity and pleasure. Post-hypnotic suggestion would focus on connecting the pleasurable experience of the erection with the partner. Associated imagery and psycho-semantics generated by the patient or therapist may also be employed to encourage the experience (e.g. "I can have a blast with my mast") (Tilton, 1981).

Arm levitation as a hypno-therapeutic technique utilizes the patients' focus on the "going up" of the arm as a result of the mental activity as a "physical metaphor" for a patient exhibiting erectile difficulties. They key element is to emphasize the lack of need for conscious control of the process and the focus on the ease and rigidness of the arm going up and staying up. As the process continues, the raised "arm" is replaced by "it" and the metaphor is completed describing "its" ability to "get up and stay up" because of the inner mind's ability to do it.

Premature ejaculation is by far the most frequent dysorgasmic complaint in men. In the finger numbness technique, hypnotic suggestion is utilized to help the patient experience numbness and insensitivity in a finger. Following this a signal for recovery of normal sensations in the finger is arranged. Once this is accomplished the transfer to the penis is effected with a post-hypnotic suggestion that the next time he copulates "his penis will feel like his finger feels now" but he will continue to maintain his erection, which will last as long as he wants and be capable of providing a pleasant ejaculation whenever he wishes.

A similar technique is utilized for retarded or absent ejaculation, whereupon a state of hyper-sensitivity is effected in the patient's finger with comparable controls, transfers and post-hypnotic suggestions.

Inadequate pleasure during sex is often closely associated with negative self-hypnosis. The therapist must examine both subjective feelings of pleasure and relational issues. Exploratory techniques, involving both members of the couple if possible, are very effective. If the focus is upon only the patient, then one technique, becoming alive, focuses upon revivifying bodily sensation. Suggestion directs the patient to increase or turn up the experiences of being alive. This energy is then directed toward the genitals. Finally, post-hypnotic suggestions direct these feelings of excitation toward the next sexual experience, associating the pleasure of life with the pleasure of sex.

Exploratory techniques can be used to uncover blocks to pleasure, including underlying guilt of fear (commonly seen in cardiac rehabilitation patients). These techniques utilized

while both participants are in trance help the patients share his/her feelings with their partner. Shared visual imagery helps partners meet on common ground and often serves to reassure the fearful or guilt-feeling member. It is interesting to not that not uncommonly it is not the cardiac patient but rather the partner who exhibits the loss of pleasure, choosing to repress his or her desires in order to protect their partner from over-excitement or over-exertion. Often NSH plays a major role for both partners in cardiac rehabilitation cases.

A final category is hypnotic techniques for dysfunctions of sexual desire and processing. In these disorders the presence of negative self-hypnosis must always be considered. Sexual abulia can be affected by relational, occupational, medical or familial stresses, which should be ruled out or examined and addressed prior to hypnosex therapy.

Sexual abulia can be addressed symptomatically, utilizing an imagery technique that again incorporates an inner representation and quantification of the dysfunction. In this technique, the patient is encouraged to imagine a computer room, emphasizing all the sensory experiences inherent within it. They can take their time and signal (ideomotorically or otherwise), when they come to the computer that controls their sexual desire. They are asked to imagine a dial or control that allows them to turn up the sexual desire. As they do, the indicator lights may change from cool blue, to warm orange, to hot red. They are reminded that they are in control, but they can perhaps notice the pleasurable sensations and images that appear as they do this. It is important to allow the patient to feel they are in control of the dial, and allow adequate time to examine any associations. A combination of exploratory techniques followed with dynamic sexual imagery has proven very effective with this condition.

Revivification can be used to help the individual relive a period in his or her life when sexual functioning was more exciting and desired. In this approach, natural use of fantasy as it occurs in most relationships is amplified. It “gives permission” to the patient (who may be feeling guilty about engaging in fantasies that do not involve his partner) to utilize fantasy during sex. Using this technique, a very good past sexual experience is chosen which is then keenly revivified. This helps the patient recognize that he or she can recapture pleasurable exciting sensations again. If past experiences are not available, the client can be encouraged to create one. If even this process proves too anxiety provoking, the patient can be invited to revivify using other characters, perhaps favorite sex symbols. In addition, sexual fantasy materials ranging from somewhat raw “off-the-shelf materials” to more professional materials specifically produced for these purposes (Golden & Mills, 1982) can be suggested. Post-hypnotic suggestions emphasize the good feelings, sense of enjoyment, and happiness that will be present when a sexual opportunity presents itself.

SUMMARY

In conclusion, it appears that self-defeating cognitive process or NSH play a crucial role in sexual dysfunctions and further, that numerous hypnotic techniques can be utilized within a cognitive framework toward uncovering etiologies, symptom reduction,

cognitive restructuring and overall functioning of the individual and/or couple involved. Hypnosis should not be seen as a total replacement for other cognitive and behavioral techniques, but rather one more valuable tool in the armament of the sex therapist.

This paper represents a brief review of the work on cognitive hypnosis for sexual dysfunctions. For a more thorough exposition on the topic, readers are directed to *Hypnosis and Sex Therapy* (Araoz, 1982). For a more comprehensive review of case studies, Dowd and Healy (1986) *Case Studies in Hypnotherapy* is an excellent source.