

THE PLACE OF HYPNOSIS IN PSYCHIATRY, PART 2: ITS APPLICATION TO THE TREATMENT OF SEXUAL DISORDERS

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This paper is based on a world-wide search of the literature focusing on the application of hypnotherapy in the treatment of sexual dysfunction. The authors review a range of treatment procedures which have been shown to be highly effective for a wide range of sexual dysfunctions listed in the DSM-IV. This paper demonstrates that hypnotherapy is a very valuable tool for a wide variety of sexual dysfunctions. Some of these treatments are behaviourally oriented, in particular the cognitive re-structuring used in the treatment of frigidity; others are more psychodynamically oriented, such as the use of age regression in the treatment of premature ejaculation; and a third group combines these approaches. Detailed accounts of the treatment procedures are given so that hypnotherapy practitioners may incorporate these techniques in their consulting rooms.

Sexual disorders, according to the *DSM-IV* classification, are divided into four main groups: (1) sexual dysfunctions; (2) the paraphilias; (3) gender identity disorders; and (4) sexual disorders not otherwise specified. This paper will be limited to an exploration of the value of hypnotherapy as applied to the first category — the sexual dysfunctions.

SEXUAL DYSFUNCTION

This extensive category includes a number of disorders associated with a disturbance in the sexual response cycle or pain with sexual intercourse.

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DSM-IV divides the sexual cycle into four phases: (a) Desire, with its associated sexual fantasies; (b) Excitement, sexual pleasure and physiological changes; (c) Orgasm, the height of sexual pleasure with its concomitance; and (d) Resolution, the sense of muscular relaxation and feeling of wellbeing.

In addition, disorders of sexual dysfunction may be divided into seven main categories as shown below:

- 1 *Sexual desire disorders*: hypoactive sexual desire disorder, sexual aversion disorder.
- 2 *Sexual arousal disorders*: female sexual arousal disorder (frigidity), male erectile disorder (impotence).
- 3 *Orgasmic disorders*: male orgasmic disorder (formerly inhibited male orgasm and also known as retarded ejaculation), premature ejaculation, female orgasmic disorder (formerly termed inhibited female orgasm).
- 4 *Sexual pain disorders*: dyspareunia (not due to a medical condition), vaginismus (not due to a medical condition).
- 5 *Sexual dysfunctions associated with medical conditions*: any of the above four caused directly by a medical condition and not accounted for by another psychiatric disorder.
- 6 *Substance-induced sexual dysfunctions*: the sexual disorder as the direct result of medication, a drug of abuse or toxin exposure.
- 7 *Sexual dysfunctions not otherwise specified*: sexual disorders where the clinician is uncertain as to its precise nature, and whether it is associated directly with a medical condition. The final three categories are beyond the remit of this paper.

SEXUAL DESIRE DISORDERS

The application of hypnosis to the treatment of sexual desire disorders are now elaborated, as each disorder is listed and discussed.

Hypoactive Sexual Desire Disorder (Also Known as Sexual Abulia)

This term is used to denote a pathological condition where there is low or non-existent desire for sexual activity, or even an absence of fantasies. This can be global in nature or limited to a particular form of sexual activity. When making this diagnosis, clinicians should make sure that the patient is not suffering from any Axis I disorder or is affected by substance abuse. In fact, low sexual interest is frequently associated with inadequate sexual arousal or with

orgasmic disorders, and as a result this often leads to difficulties in maintaining a permanent relationship and may also cause marital disharmony. A low sex drive can be lifelong or acquired, and may be situational or generalised. Several authors have addressed the problem of hypoactive sexual desire disorder, notably Stafano (1982), Bakich (1995) and Araoz (1980).

Stafano (1982) gave a detailed account of a 23-year-old married lady who had no sexual desire for her husband, scoring 0/10 on a sexual desire scale. All sexual activities, including fondling, kissing and penetration, evoked feelings of tension, and she tried to avoid sexual activity by increasing her teaching workload. She would only have sex with her husband in order to please him and wanted it to end as quickly as possible. Stefano focused on age regression and, early in the therapy, it was revealed that she had had a disastrous wedding night. Further work revealed that, from the age of 14 to 16, her controlling stepfather prevented her from dating, insisted that she always had to return home by 10 p.m., and screened all her phone calls. Next, it was uncovered that the only time she had ever touched a male's genitals was at the age of 11 when she saw a boy urinating. At the same age, she happened to walk into the bedroom where her mother and step father were having sexual intercourse, and this had led to her mother hitting her and describing her as a "dirty, filthy young lady."

The treatment of this patient was based on the "elevator technique" (Macvaugh, 1979). In hypnosis, she was instructed to imagine herself in an elevator at the 20th floor, and to regard it as a visually stimulating and colourful experience. The patient was surprised to find that the door handles were replicas of her husband's penis and the author utilised this imagery by giving her suggestions that the door handles were attractive to her, that they were beautiful and completely natural objects. She was encouraged to react favourably to the penises. Gradually her tension lessened as she became more susceptible to these direct suggestions, and her feelings intensified as the elevator descended from one floor to the next. In addition, she was encouraged to imagine bringing her lips to the penises and moving them all over her body.

Subsequently, the author introduced the "desert island experience," in which the patient was encouraged to feel the warmth of the sand and water in order to promote pleasant sensations in the vagina and breasts. Further work using the regressional technique uncovered a sexual experience with her grandfather at age six which, at that time, produced sensations which she could not understand, while the final regression elicited a scene where her mother

wished to destroy the foetus first by hitting her abdomen and secondly by inserting knitting needles into her vagina.

The net result of the therapy was extremely rewarding, as she not only became capable of having an open and fulfilled relationship with her husband, but she was also able to explore and respond to his sexual touch. She later became pregnant and was able to cope with the whole of her labour, without the need for analgesics, by using self-hypnosis and the “desert island technique.”

A similar approach using a regression technique was employed by Bakich (1995) to uncover sexual traumas in a female patient who had a lack of sexual feeling in the last five years of her marriage. She was regressed to the age of 12, when she had experienced her landlord touching her breasts and genitalia. In particular, she experienced flashbacks of the landlord’s “hairy hand.” The therapist encouraged her to “let go” of this “hairy hand” in hypnosis, and he suggested to her that it would only be her husband’s hand that would be close to her. She was also given ego-strengthening (Stanton, 1993) to improve her low self-esteem.

A most unusual case was reported by Araoz (1980), who treated a 37-year-old married man who had never experienced any form of enjoyable sexual activity, even though he had three children. It was clear from the preliminary history taking that he had been primarily concerned with his intellectual pursuits, as this had been strongly encouraged by his family throughout his life, and this might well have had interfered with his sexual enjoyment. As he had never enjoyed sexual activity in the past, he was encouraged to try to invent new, pleasurable sexual scenes during the hypnosis.

Lifelong hypoactive sexual desire disorder is more difficult to treat than the acquired variety; and it is far simpler to treat patients who can recapture pleasurable sexual experiences. The focus of the treatment was to build up a pleasure hierarchy, and the patient was asked to list a series of potentially enjoyable aspects of sexual activity with his wife. They were as follows:

- when his wife embraced him,
- when he rubbed accidentally against his wife’s naked body in bed,
- when his wife showed “urgency of desire” while making love,
- when she massaged his chest and abdomen, and
- when he massaged her thighs and buttocks.

Araoz skilfully devised a series of elaborate sexual and sensual fantasies which appealed to visual, tactile, and olfactory sensations. The patient was encouraged to enjoy these sexual fantasies and to associate these with feelings of relaxation and wellbeing.

An important strand of the treatment was the two post-hypnotic suggestions. The first was that the patient would experience these good feelings before going to bed with his wife, and the second was that these feelings would be initiated by his wife's embrace. He was also instructed to use self-hypnosis with the aid of an audio tape and this was to be used on a daily basis. The whole of the treatment was achieved in only two sessions; however, there were also two mini sessions on the telephone where the post-hypnotic suggestions were reinforced. This patient made a remarkable recovery in a very short space of time and was able to enjoy sexual intercourse with his wife three times a week.

Sexual Aversion Disorder

This is a disorder in which the patient is repulsed by sex, and this ranges from a mild anxiety to a severe disgust and avoidance of all sexual activity. The sexual aversion may be limited to certain aspects, such as kissing or vaginal penetration, or may be more global. In severe cases, the aversion is so strong that the mere prospect of sexual contact can lead to panic attacks.

Bakich (1995) described a 31-year-old married lady who met the criteria of sexual aversion disorder. She came from a happy background and had no idea why she should find sexual activity with her husband disgusting. All forms of sexual activity — viewing or touching the penis, as well as sexual intercourse — made her feel “yucky,” and she stated that she would do anything to correct this disturbance. In particular, she hated the wetness and stickiness of the seminal fluid.

The author used the “diary technique,” in which the patient was asked in hypnosis to imagine a page with the numbers 1–31 running backwards, each number representing a year of her life. Using ideomotor signalling, she stopped at the age of 16, at which point she became visibly nervous. On enquiry, she said that she had had her first sexual encounter with a man several years her senior. She went on to describe the sexual activity which consisted of the man ejaculating and spreading the seminal fluid over her body, and then urinating over her. She sobbed and was unable to touch any part of her body at this point.

In order to combat her feelings of disgust, a systematic desensitisation approach was employed in which the patient was asked to visualise being naked with her husband. Gradually, in hypnosis, sexual contact was increased and, whenever she felt distressed, she was returned to her special place.

A telephonic enquiry a few months later indicated that she was now able to cope with sexual intercourse with her husband. The whole treatment was achieved in four sessions.

SEXUAL AROUSAL DISORDERS

Female Sexual Arousal Disorder (Frigidity)

The essential components of female sexual arousal disorder include a persistent inability to produce an adequate lubrication-swelling response to sexual excitement, inadequate vasocongestion in the pelvis, and a deficient swelling of the external genitalia. In order to make this diagnosis, it is important to exclude patients who have any medical condition which might interfere with adequate sexual arousal such as diabetes mellitus and atrophic vaginitis.

Several approaches have been used in the treatment of frigidity, notably that of Araoz (1983), who obtained high success rates with cognitive restructuring in the treatment of sexual arousal disorders. When treating patients suffering from frigidity, he observed that frequently these women made negative statements about themselves, which, in turn, led them to believe that they were “sexual failures” and that they could not do anything about their problem. As a result, they developed a very low self-image. In the treatment, he emphasised the importance of changing strong, negative statements such as, “I’ll freeze all over next time he touches me” to more positive statements (“counteractive cognitions”) which are elicited by the patient. These might include the following:

- I’ll experience new sensations next time he touches me.
- I’ll become more aware of what it feels to be touched.
- I can learn to react positively to his touch.
- I can see myself enjoying his touch, feeling nice and warm.
- I’ll become more directive, so that he touches me the way I want.

In addition to using these phrases during the treatment sessions, it is important to reinforce these statements in self-hypnosis. The value of hypnosis and self-hypnosis was established by Araoz in a large study involving 200 couples, of whom 50 had traditional sex therapy and 150 were treated with hypnosis in addition to the traditional sex therapy. At one year follow-up, there was a large difference between the non-hypnosis and hypnosis groups: He found that only 10% (5/50 patients) who had received traditional sex therapy were satisfied with their treatment, whereas 70% (105/150 patients) of the hypnosis group were happy with the treatment results and continued to

use self-hypnosis regularly. Interestingly, many of these patients used hypnosis to help them with other problems such as flying phobia, going to the dentist, and migraine attacks.

An alternative approach to the treatment of frigidity is the “red balloon technique” described by Walch (1976). The patient was a young married woman who was well aware that she had guilt feelings regarding pre-marital sexual intercourse, but felt completely at a loss to know how to deal with them. This technique is particularly helpful for those patients who experience a lot of guilt and where this is central to their frigidity. The “red balloon technique” was described by the author as being “hypnocathartic.” It was suggested in hypnosis that the patient should visualise a sturdy container where she should off-load a large proportion of her guilt feelings and other unpleasant thoughts. She was also instructed to imagine a large red balloon and to fill it with helium. When the balloon was filled, she was encouraged to fasten the container to the balloon, to loosen her grip and to watch both balloon and container floating into the distance. It was suggested to her that, as the balloon receded into the distance, her feelings of guilt would be greatly diminished. During hypnosis, the therapist noticed the patient smile and her head move in an upward direction as the balloon drifted off into the distance. A week later, when she came for her next treatment session, she was obviously feeling a lot better, and she asked to “send up another balloon.” After two additional treatments, she reported being able to achieve sexual climax.

A completely different treatment approach is that used by Metcalfe (1988), in which patients were encouraged to imagine a ball of clay in hypnosis — he referred to this as the “modelling clay technique” or “hypnoplasty.” The aim of the treatment is that the clay should take on a form which is significant to the cause of the symptoms. In particular, this technique is extremely helpful in allowing patients to abreact their angry feelings towards parental figures. When the patient has been able to release her feelings of anger towards her parents, it is no longer necessary for her to project these feelings onto her partner. This, in turn, relieves her of her frigidity.

An alternative approach is one used by Oystiragh (1980), who employed automatic writing in hypnosis as a way of un-earthing a number of problems relating to frigidity. The author gave a detailed description of a 28-year-old married lady who had had a rather unhappy childhood, in which she was moved from one foster home to another, and was also raped at the age of 9 and again at the age of 11. Ostensibly, the problem was one of obesity, but it was soon established that she had a series of psychosexual problems — she didn't

like undressing in front of her husband, had difficulty touching her husband's penis, and did not particularly enjoy sexual intercourse. The treatment strategies included age regression, abreaction and, in particular, automatic writing in which the patient was given a pen and paper in hypnosis and asked to write down what she felt. It was suggested that she, "let her hand do all the work" and that she should write down whatever was troubling her.

In one of these sessions, she wrote down some words and phrases, and later she was asked to decipher them. The key words and their connotations are shown below exactly as written by the patient:

- Hurts me — during penetration.
- Dirty — sweaty, wet, sticky feeling, smell of body.
- Animals — men use ladies like animals. All they want is physical release. They don't care whether they hurt.
- No love — remembers mother and all the different men. How can all these men love mum. They only want to use her body. They want to use my body.
- Ugly body — mother's body got ugly, got fat and I'm fat.
- Can't love — wants to love people, but is frightened that she will be all alone again.

This patient made an excellent recovery: she no longer needed to switch off the light when undressing, she enjoyed and initiated sexual intercourse and could also cope with fondling. A six month follow-up showed that her considerable improvements were maintained.

Male Erectile Disorder (Impotence)

This is defined by a persistent inability to obtain or maintain an adequate erection and must not be associated with any medical condition such as spinal cord injury, vascular conditions involving the penis, diabetes mellitus, and multiple sclerosis. When making the diagnosis, one must take into account that, in older age groups, more stimulation is required to achieve adequate erections.

Impotence which is present from the onset has been termed "primary impotence" (rare), whereas impotence occurring after normal sexual function has been called "secondary impotence"; however, in the *DSM-IV* classification, these phrases were replaced by the terms "lifelong" and "acquired" respectively. In clinical practice, it is important to distinguish these, as it is much easier to treat patients who have had normal erectile function in the past than those who have not.

Frederick (1991) described the successful treatment of a 38-year-old male patient who sought treatment for an impotence problem which was causing him distress in his second marriage. The therapist employed a hypnoanalytic approach to the problem, and, during the course of the therapy, a number of important issues came to the fore:

- His mother was the major influence in his life.
- His mother caught him masturbating as a teenager.
- His mother gave him negative cues about girls and the evils of sex.
- He often visualised his mother while masturbating.

He had projected his feelings about his mother onto his wife (who bore a close resemblance to her in many respects), and this echoed the feelings of sex being taboo. In the treatment sessions, Frederick, using a combination of psychotherapy and hypnotherapy, concentrated on separating the mother/wife identification. A number of treatment strategies were used including cognitive restructuring, ego-strengthening and the “sensate focus” approach of Masters and Johnson (1970). At the 10th treatment session, the patient reported that he was able to have full sexual intercourse with his wife, and this improvement was maintained at three month follow-up.

An entirely different approach was used by Stanton (1990), who described a method of treatment which he referred to as “double dissociation.” The patient was asked to imagine sitting in the middle of a cinema watching a black-and-white snapshot of himself prior to a failed sexual experience. He was then instructed to float out of his body into the projection booth where he could “watch himself watching the screen.” In this way, the patient was able to distance himself from the experience and became less upset about it. Next, he was encouraged to watch a black-and-white film of himself having a failed sexual experience; at this point, the film was converted into colour and was played backwards. Finally, the therapist used a re-framing technique where the film was run forwards again, this time depicting a successful sexual outcome.

In treating such cases, some therapists prefer to concentrate on producing powerful arm rigidity in hypnosis, with the view to transferring this to the penis. Crasilneck (1992) used this direct approach when treating impotence. During the hypnosis session, the patient was asked to extend his dominant arm and told to feel the muscles in his forearm; the patient was then repeatedly given direct statements that the arm was completely rigid and made of steel. The patient was then asked to open his eyes and to observe the strength in the muscles of his arm, before closing his eyes again. He was then told that if he could produce this rigidity in one part of the body he could reproduce it

in another, that is, in the penis.

It has been suggested by Fuchs, Zadise, Peretz, and Paldi (1985) that the arm levitation technique has symbolic value for these patients and might well enhance the effectiveness of the treatment.

ORGASMIC DISORDERS

Female Orgasmic Disorder (Formerly Inhibited Female Orgasm)

The essential feature of this disorder is that there is a delay or absence of orgasm after an adequate amount of sexual stimulation. The therapist must assess this in relation to the age of the patient, past sexual experiences, and the amount of sexual stimulation she received prior to, or during, intercourse. Again, this disorder may result in low self-esteem and might have an effect on interpersonal relationships. Generally, orgasmic disorder is lifelong rather than acquired; however, once women have acquired the ability to reach orgasm, this tends to be maintained, unless there they have had a traumatic experience, a mood disorder, or have suffered from a general medical condition.

Smith (1975) reported a case of a rather immature woman aged 28 who had failed to reach orgasm at any time throughout the eight years of her marriage. An exploration revealed that, having had a very close relationship with her father, and having referred to herself as “Daddy’s little girl,” she considered herself more as a daughter to her husband rather than a wife. Indeed, her father bore a very close resemblance to her husband. During the hypnotherapy session, the therapist emphasised that she was making love to her husband and not to her father. The treatment was highly effective and she was able to reach climax with her husband when having sexual intercourse. This was maintained at follow-up, and she continued her psychotherapy which focused on ensuring that her own desires were met in the bedroom.

Smith described two other female patients who had an acquired orgasmic disorder, both of whom made an excellent recovery. One of these patients was a highly dependent and immature female, aged 36. Her problem could be traced to her in-laws and the fact that her husband did not support her adequately. She could not cope with criticism from her in-laws and she turned to alcohol and drugs as an escape route. In addition, she used the lack of orgasm as a way of punishing her husband. In the hypnotherapy sessions, her attention was drawn to the fact that she was not only punishing her husband, but that she was also punishing herself, and that more mature patterns of behaviour could be learned. As a result, her husband became more supportive, and once these

issues had been resolved she was able to be orgasmic once more.

An alternative approach was one used Stewart (1986), who used hypnoanalysis in the treatment of a 33-year-old woman who had lifelong anorgasmia. This was caused by underlying conflicts in her early childhood. She stated that she felt that she was unable to “let go,” that she never really enjoyed sexual intercourse, and that she became distracted shortly before orgasm. Hypnoanalysis revealed that her parents were undemonstrative and never showed any affection towards one another. In hypnosis, she revealed that, at the age of five, she had a doll on which she lavished her affections and used as a lover. She described putting lipstick on and transferring this to the doll; her mother caught her doing this and scolded her embarrassingly in front of her family and friends. From the age of five onwards, and into adolescence, she used the doll for masturbation purposes and this remained her “secret” for 27 years; in fact, this had had a profound effect on her sexual development. She had associated the doll with punishment and the fear of further punishment, and this then interfered and perpetuated her inability to reach orgasm in her adult life.

During the course of the therapy, the patient began to understand the unconscious processes which had interfered with her reaching orgasm, and this proved to be very helpful in her recovery. The outcome was that she not only felt more comfortable with men in general, but was also able to enjoy sexual intercourse and orgasm.

Crasilneck and Hall (1985) favoured a combined approach of direct suggestion — focusing on the sensitivity of the vagina and clitoris — and psychodynamically orientated psychotherapy. They also stressed the importance of bringing the husband into the treatment sessions, as the wife’s lack of orgasm may well undermine his sense of masculinity (Degun & Degun, 1991).

Premature Ejaculation

The term premature ejaculation denotes a rapid male orgasm which may occur either before penetration takes place, or during sexual intercourse. This condition is distressing for both partners because it does not give the female any chance to enjoy the sexual experience. Important variables include the age of the patient, the novelty of the sexual partner or situation, and frequency of sexual activity.

The standard approach to the treatment of premature ejaculation is the “squeeze technique” (Kilmann & Auerbach, 1979). This technique does not require the assistance of hypnosis. Here, the woman is instructed to squeeze

the frenulum with the thumb and to use her two fingers to grip the penis for 15 to 30 seconds. This has the effect of reducing the erection, and is followed by further stimulation. This cycle is repeated many times over a period of 20 minutes and, as a result, it has a delaying effect on orgasm.

Erickson (1973) described the successful treatment of a 38-year-old male patient who had suffered from premature ejaculation for 19 years. The technique that he employed with this patient — which we will refer to as the “wristwatch technique” — was to use a series of post-hypnotic suggestions involving symbolism, and an enormous amount of emphatic and repetitious language. First, he was instructed to buy a wristwatch with illuminated hands, and he insisted that it had a second hand; second, he was told that he would fail to reach orgasm for 10, 15, 20 minutes, and then later 25, 25½ and 26 minutes. Third, he was told that, however much he strived, he would be unable to reach orgasm and that he should concentrate all his attention on the wristwatch. Later, he was asked to imagine bringing a girl home to his apartment, and he was told to concentrate on the cracks between the paving stones with a feeling that the path to his home was never-ending. The length of the walk home had symbolic value for the patient and this had the effect of holding off the orgasm. Erickson reported that the patient married 18 months later and had made an excellent recovery from his premature ejaculation.

A 23-year-old male patient suffering from premature ejaculation was successfully treated by Stricherz (1982) using a combination of age regression and abreaction. He was regressed to the age of six and this released a great deal of emotionally charged material. During this abreaction, he described a scene in which he was in bed with his mother who was caressing him in a sexual manner at a time when his father was out of the house. When his father returned, the patient felt blows to his body and could hear a loud, vibrating voice shouting at his mother. As the therapy progressed, attention was focused on his repeated failures throughout his childhood and the therapist made the direct suggestion that he would “fail to fail.” The following week, he was able to maintain an adequate erection during intercourse and this was maintained for a period of 2½ years.

Male Orgasmic Disorder (Formerly Inhibited Male Orgasm or Retarded Ejaculation)

This is a condition where the male partner experiences extreme difficulty in reaching orgasm during sexual intercourse, although it may be possible for him to reach orgasm in sexual activity not involving intercourse, such as manual or

aural stimulation. Some men, however, can experience orgasm during coitus, if they have received a great deal of prior stimulation.

Pettitt (1982) used a series of approaches when treating a 33 year old man who had suffered from retarded ejaculation for many years. The patient had 30 hours of therapy over a six-year period. The treatment strategies included:

1. Ego-strengthening and improving feelings of warmth towards his wife.
2. Re-capturing times when sexual activity had been enjoyable.
3. Hallucinated hypnoplasty which involved imagining modelling with clay — first, releasing angry affect, and second, balancing this by creating a piece of beautiful sculpture.
4. Time distortion.
5. Use of imagery and symbolism, focusing on the germination of seeds into a golden flower, symbolising the awakening of sexual arousal.
6. Dream interpretation.

In the dream work, the author employed a gestalt approach in which the patient was required to take on all the respective parts of the dream. He was then encouraged to describe the life of each character and to offer his own interpretation. In addition, he was instructed to project himself into the future at a time when he no longer had these problems: Here, he decided to give himself two targets — first, to become closer to his wife, and second, to take life less seriously. At follow-up, he reported that he was now able to have simultaneous orgasm with his wife, although he still required some manual stimulation prior to sexual intercourse.

SEXUAL PAIN DISORDERS

Dyspareunia

Dyspareunia, a term which was first introduced by Dupuytren in 1839, denotes pain which some women experience during sexual intercourse: This pain is not associated with either vaginismus or a lack of lubrication. The pain which the women experience may range from mild to severe, sharp pains. Patients who complain of dyspareunia tend to go to their general practitioners for advice, but examination fails to reveal any physical abnormality; nevertheless, individuals who suffer regularly from this condition often avoid sexual experiences or meeting potential new partners.

Kandyba and Binik (2003) described in detail the treatment of a 26-year-old single woman who had been suffering from dyspareunia for three years. The main feature was that she suffered pain on penetration — stabbing and

burning sensations — which lasted for one minute and then would subside during sexual intercourse. Following coitus, again she would experience burning sensations when passing urine. Interestingly, her dyspareunia did not affect her sexual desire: There was no evidence of vaginismus and she was motivated to come for treatment to alleviate this pain.

The first aim of therapy was to ensure that she could insert two fingers into her vagina without any pain, and this was achieved with the use of pelvic floor physiotherapy. The patient received 12 sessions altogether in which the therapist used a combination of psychotherapy and hypnosis. The emphasis of the hypnotherapy was to counteract anticipatory anxiety and this was achieved by the use of the special place. This approach was effective in reducing pain.

During assessment, it was established that the patient's mother suffered from a bipolar affective disorder and that she constantly berated her daughter, as she did not like the close relationship that she had with her father. It was also established that, at the age of 12, her parents divorced and she had to spend several years in a foster home because her mother was unable to look after her.

In the hypnotherapy, the patient was encouraged to imagine a special place where she felt comfortable and relaxed; she was then asked to imagine having sexual intercourse in that place with her present partner. Positive suggestions were then given to encourage feelings of comfort and satisfaction. The next treatment objective was to reduce the pain. She was asked to imagine the pain and to switch it off like a light switch. She also was instructed to visualise the light switch and to see herself turning it off; this was important as it gave her the feeling that she was now in control of her own pain.

Even after the first hypnotherapy session, there was a dramatic improvement with regard to her pain, but this returned when she had sexual intercourse for the second time. However, at this point she was able to use the electric light switch approach to eliminate the pain. She did not re-experience any pain from then on, and gradually anticipatory anxiety was reduced to a minimum and she reported that she had “control” over her pain.

A telephone follow-up interview after two months showed that she had been pain free, and that she only had brief thoughts about experiencing pain; a further telephone interview at 10 months confirmed that she had remained symptom free.

The authors pointed out that the excellent prognosis for this patient may, in part, be due to the very brief duration of pain during intercourse and also that she had no interference with sexual desire. It was postulated that, women

who have always experienced pain during sexual intercourse might require a more lengthy treatment program.

Vaginismus

This term, first described by Huguier in 1834 as the title of his MD thesis, is used to denote a spasm of the perineal muscles surrounding the outer third of the vagina. Vaginismus or vaginal spasm may be precipitated by sexual intercourse, the insertion of a finger or speculum, or merely the prospect of any of these taking place. The spasm may range from slight pains or may be so severe that sexual penetration becomes impossible. Women who suffer from vaginismus tend to have normal sexual arousal and an adequate amount of lubrication but still experience vaginal spasm on penetration.

Aetiological factors which may lead to vaginismus include previous sexual traumas, such as rape or incest; a reluctance to accept sexual intercourse within marriage when punitive attitudes have been expressed to pre-marital sex; homosexual orientation; previously traumatic pelvic examination by gynaecologists; and fear of pregnancy. An important feature of vaginismus is a faulty psychosexual development leading to a phobic reaction to sexual intercourse.

Fuchs (1980) described a 23-year-old married woman who had vaginismus, a fear of pain and a resistance to any attempt at having sexual intercourse. He treated this patient using the “in vitro” method which involved the construction of a graded anxiety hierarchy of increasingly erotic sexual situations. After an initial history taking, she was introduced to hypnosis and was asked to imagine this graded series of sexual situations. Finally, she was asked to visualise having sexual intercourse. After the ninth session, she reported that she was now able to have full sexual intercourse without any vaginismus, and she also reported that she had lost her other three phobias — claustrophobia, the phobia of the dissection of fish and chicken, and phobia to the pictures of childbirth.

Fuchs went on to describe another patient who previously had had a hymenectomy and who had subsequently developed a fear of gynaecologists as well as an acute awareness of her vaginismus. After being taught self-hypnosis, she was invited to insert a series of dilators into her vagina, and after three weeks she was able to achieve sexual intercourse without any vaginal spasm. This technique was described by Fuchs as the “in vivo” technique.

The outcome was excellent in both categories. Good results were obtained in 16 out of 18 patients by the “in vitro” technique and 53 out of 54 patients

using the “in vivo” technique. Fuchs (1980) emphasised the importance of not carrying out surgical procedures on these patients, because this does not improve the situation and, if anything, it intensifies the symptomatology. Apart from causing scarring from the surgical incision, it also causes psychological damage.

Delmonte (1988) described the case of a 32-year-old married woman, Mary, who was suffering from vaginismus. Here, there was evidence of previous sexual trauma and she associated coitus with violence. Indeed, this trauma consisted of a combination of sexual abuse and violence. A number of treatment strategies were employed, including hypnotherapy, Jacobson’s (1938) progressive muscular relaxation, yoga, and a number of breathing exercises.

She made a good recovery in five treatment sessions and this was maintained at six month follow-up. After one month, she reported that she practised relaxation daily and was able to have sexual intercourse every night without pain. Six months later, Mary reported that sexual intercourse was now satisfactory and that she had a good relationship with her husband.

CONCLUSION

This paper has demonstrated quite clearly that hypnotherapy is an extremely valuable tool in the treatment of sexual dysfunctions, a treatment approach which does not involve the use of any medication. A recurring theme throughout this paper is the role of sexual trauma in the psychopathology of sexual disturbances; for example, sexual trauma may be a cause of hypoactive sexual arousal disorder, sexual aversion disorder, frigidity, impotence, female orgasmic disorder, premature ejaculation, and dyspareunia.

On reviewing the global literature, it is apparent that some authors restrict their treatment to a behavioural approach, such as the use of cognitive restructuring for frigidity (Araoz, 1983); other authors prefer to concentrate on the causation of the problem, such as the diary technique used by Bakich (1995) in the treatment of sexual aversion disorder; while a third group uses a combination of these, for example, Crasilneck and Hall (1985), who employed a combination of psychodynamically orientated psychotherapy and direct suggestion. Excellent treatment results have been obtained with all of these approaches and this demonstrates that there is no real antagonism between the behavioural approach and the psychoanalytic approach (Kraft, 1969). The advantage of hypnosis, compared to psychotherapy, a much lengthier process, is that it can focus quickly and immediately on the causative factors which have been responsible for the sexual disorder and effectively pinpoints the date,

time, and precise nature of the disturbance. Hypnotherapy offers a rapid and cost effective form of treatment for sexual disorders, and it is recommended that these procedures are used in therapy.

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