

Hypnosis in Human Sexuality Problems

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This is a general overview of the use of hypnosis in five aspects of human sexuality where problems or pathology may move patients to seek therapy. These are gender identity, sexual orientation, sexual preferences, sexual functioning and sexual mores. The article emphasizes two main hypnotic techniques that respect the patient's existential experiences regarding his/her own sexuality. The use of hypnosis proposed here is patient-centered, permissive and utilizing the patient's imagery and other inner resources. Several clinical vignettes illustrate the theoretical points with the intention of giving the reader an opportunity for identification with these cases.

Keywords: Gender identity, human sexuality, sexual functioning, sexual orientation

The behavioral use of hypnosis (for symptom alleviation) has been quite popular among those using clinical hypnosis. This is also the case in the field of human sexuality that for most people is limited to sexual functioning, as Wiederman (1988) indicated.

This paper suggests a wider and deeper understanding of human sexuality as being essentially different than that of other mammals because of our ability to self-reflect and introspect. Seligman (1993) proposed the rings metaphor, like those of an old cut-down tree, for human sexuality. In the old tree the innermost rings are the oldest or most primitive and the others appear as "later realities" of the growing tree. So too with human sexuality: One's identity precedes sexual orientation, preferences and so on, and the younger or newer aspects of sexuality build on the old ones. The complexity of human sexuality and its uniqueness lend themselves to the use of hypnosis to improve

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sexuality and to enjoy it more. Research (Carrese & Araoz, 1998) has shown that approaches including hypnotic techniques in sex therapy are more effective than those without hypnosis.

In this paper, I am referring to less traditional hypnotic techniques, more permissive and patient-centered than commonly used before Erickson's (Erickson, Rossi & Rossi, 1976) innovative methods. They have been referred to as *new hypnosis* (Araoz, 1995; 1998; Godin, 1992, Weitzenhoffer, 2000) because they combine Ericksonian techniques with cognitive-behavioral modalities (Bandura, 1969; Ellis, 1962), without however losing sight of unconscious psychodynamics which were the central focus of hypnosis since Freud's time. This "new" hypnosis avoids artificial and standardized inductions and starts from the mental activity of the patient, using his/her own mental resources. It emphasizes experiential, non-intellectual, ways of learning about oneself. In this article I limit myself to two of these techniques which have a wide range of application.

In using the new hypnosis for human sexuality there are four characteristics. First, it is centered on the patient, as just mentioned. Second, it doesn't strive to necessarily make the unconscious conscious (Camino & Gibernau, 1997) but, respecting the unconscious, it encourages the patient to focus on the positive aspects of it and to trust it. Thus and third, it is constructive and positive (Araoz, Burte, & Goldin, 2001). And fourth, it utilizes the relationship in a systemic way to enrich the hypnotic experience of the individual identified as having a sexual problem, often involving the "patient's" partner (Araoz & Kalinsky, 1987).

This paper is a general overview of the use of hypnosis in human sexuality problems. As such it presents concrete illustrations of problems in each "ring" treated hypnotically, using brief clinical vignettes for the purpose of practical clarification.

Gender Identity

Sexuality, in humans, starts with one's sexual biology, which in most cases creates an identity designated as gender. Grand (2003), among many others, defines sex as biological and gender as psychological, thus recognizing with Fausto-Sterling (1993) three sexes (male, feminine, hermaphrodite) and five genders (the same three plus, masculine woman and feminine man). Gender needs a concise definition, as "the sense that one is a man or a woman, from a person's sexual orientation" (Drescher, 1998, p. 16). Early in childhood this is simple in most people ("I know I am a boy or a girl") and continues to develop later finding new meaning for sexual desire, sexual pleasure, and sexual union. This development of meaning moves from sheer physical drive and relief to sexuality as a spiritual symbol of the human being. Hypnosis helps people with questions and problems about their unique identity in three different ways. First, with hypnosis it becomes more economical and effective to explore and investigate the patient's questions about his/her doubts. Second, hypnosis allows the patient to experience what it would be like to be of the other sex and gender by the method of *mental rehearsal*. Third, if the patient comes to the decision of changing his/her sex surgically, hypnosis benefits the patient by keeping him/her motivated, to prepare for the surgical ordeal, to control pain and to adapt more fully to the new life that a sex change implies.

The problem appears when people have had genuine doubts about their sexual identity or claim that their body and mind are in conflict regarding it (Benjamin, 1966).

According to Cole, O'Boyle, Emory, and Meyer (1997) a transsexual is the person whose gender identity is opposite to that of his or her biological sex. The explanation for this anomaly is still far from certain and beyond the scope of this article. Reliable texts on human sexuality, like the one by Crooks and Baur (1999), detail the difficulties in understanding this condition that some (Blanchard, Legault, & Lindsey, 1987) have called *gender dysphoria*. In the USA, this is known as *gender identity disorder* (DSM-IV, 1994).

After ascertaining in clinical practice that there is truly gender dysphoria, the hypnotherapist helps these patients to identify hypnotically with both sides of their life experience, the masculine and the feminine. This is done by the technique of activation of personality parts, which is an adaptation of Watkins & Watkins (1997) Ego State Therapy. Once the patient mentions the identity conflict, he or she is invited to connect mentally and imaginatively with each identity or personality part. The identification with different personality parts allows the patient to own both aspects of the self.

If the patient with a gender identity problem is a woman, the first personality part to concentrate on is the feminine, and vice versa if the patient is a man. Then patients are asked to listen to what this "part" of themselves is saying about their sexuality. Later they listen to the contrary part. The therapist encourages them to avoid reasoning and logic and to focus on their inner experience of being outwardly masculine or feminine and later to do the same with their inner, subjective experience of the opposite gender. Then, projecting themselves into the future, they are asked to imagine themselves as male (for women) or as female (for men). This hypnotic technique is called *mental rehearsal*. They must experience in their mind what it feels to be of the opposite sex in real life, getting into as many details as possible.

Fausto-Sterling (1985) referred to this identity problem as a mistake of nature. Green and Fleming (1990) stress that in true gender identity disorder there is a disconnect between biology and psychology. Money and Wiedeking (1980) and Seligman (1993), among others, believe that sex-change surgery is the solution for this conflict. When the patient is unable to develop a gender congruent with his or her sex, mental rehearsal can benefit these patients to prepare themselves for the drastic and permanent change. Besides these hypnotic techniques, these patients need much support and encouragement to make this decision and to persevere during the long months that the surgical sex inversion takes. Among the different types of support required (family, friends, co-workers) is the participation in therapy groups for people with this problem.

The case of Joey, I hope, illustrates the advantages of hypnosis in these difficult circumstances. He was a 20-year-old who had grown up in a very male-centered Italian family; though he was small, slim and short, he described his condition as feeling for many years that he was crazy. He knew he was a man and acted as one. But the persistent thought that he was or should be a woman never left him. He confessed with shame that several times he had tried on women's clothes and makeup, but that he was deadly afraid of anyone knowing about it. He added in a reflective way that he was surprised at the peace, happiness, and lack of sexual arousal that he felt when he cross-dressed. His only sexual outlet was masturbation. He thought it would make him feel more like a man and would make him want to be a man. But paradoxically, when he did it, he felt more angry than at other times for not being a woman, without sensing the inner peace of the cross-dressing experience. Many personality evaluations and a chromosomal test

convinced the therapist that Joey's problem was real. By connecting hypnotically with his "two personality parts," the male and the female, Joey started to realize that he was not crazy and, even though his condition was difficult and far from common, he took the next step by practicing mental rehearsal, starting to experience, hypnotically, what it feels to be a woman. Fearful at first and undecided, he tried it and practiced it frequently. Thanks to it, Joey found and joined a group of men who were getting ready for the transsexual operation.

He continued in hypnotherapy as Jo when he changed names. Two years later, fully incorporated in society as a woman in a new location out of state, she found good employment. The family had first disowned her except for one of his sisters, who remained very close to her and through whom the whole family was slowly reconciling itself to Jo as their daughter and sister. Eventually she established a good relationship with a man who accepted her fully after learning Jo's sexual identity odyssey.

Sexual Orientation

This is experienced also normally quite early in life. The young child knows that he is attracted to children of one sex or the other and feels comfortable with those who belong to the one he or she is attracted to. In therapy one finds people confused about their spontaneous attraction to those of the same sex and their lack of romantic or sexual interest in those of the other sex. To believe in choice when it comes to sexual orientation, as the proponents of "conversion therapy" (Brancoft, 2003; Morrow & Beckstead, 2004) seem to do, is contrary to what has been learned in the last two decades or so about the importance of biological factors in sexual orientation (Bell, Weinberg & Hammersmith, 1981; Hamer, 1993; LeVay, 1991, 1993). Hypnotic techniques, such as personality parts and mental rehearsal, are very helpful in these cases. The patient has to accept what cannot be changed and adjust constructively to that situation. But this has to be done experientially and reason alone does not produce positive results.

The case of Mary, 28, may be illustrative. She was an industrial engineer who had been raised in an observant Protestant family that believed homosexuality was sinful and evil. For many years she had been "fighting" her sexual orientation and had forced herself to date and eventually to marry at the age of 25. This had been her big secret. Her husband shared the same conviction as her family about homosexuality and was actively involved in homophobic causes. She participated in sexual intimacy with him, faking interest and orgasm, but she always had to "finish" by masturbation during which she fantasized about women and reached an orgasm. Eventually the husband became very angry about her post-coital practice and they saw a minister for couple/sex therapy. In this "therapy" she was told to please her husband and to do what he wanted sexually. What followed were several weeks of "horror and humiliation," with recrimination and anger on the part of the husband for not being able to conceive. In a sense, this became a blessing in disguise because the husband, due to the lack of satisfaction, requested a divorce after only two years of marriage. After the divorce, a gay friend suggested therapy. The most difficult part for Mary was to accept that she could not change her sexual orientation and that it was not from "the devil," as her family had taught her. The therapist contacted a minister of her religious denomination who was well trained in psychology. He reassured her and encouraged her to stay in therapy.

In using the personality-parts hypnotherapy technique she discovered the fearful, literal part that had believed for many years that homosexuality was evil and still had not grown up. But she also uncovered the mature part that, believing in God's love, wisdom, and mercy, trusted the sexual tendencies and attractions she could not avoid. All during her therapy she maintained contact with the minister mentioned earlier. With the teamwork of psychology and religion Mary found the strength needed to proceed in spite of her family's pressure to date and to get married again. In the practice of mental rehearsal, she used some of the fantasies she had had during the post-coital masturbation when she was married. Even though previously she had felt very guilty about these mental images, she was able to utilize them from what she called "the more mature and true believing" part of her personality. After close to 30 months in therapy, she felt happy and at peace being gay and started a close relationship with a woman who had had similar experiences in her life and who was also very religious.

Sexual Preference

Later, in adolescence, the human being is faced with his or her sexual preferences, the "things" (activities, sights, scents, etc.) that arouse in him or her sexual desire and lead to individual sexual satisfaction. These "things" include, among others, specific parts of the human anatomy and body type, physical sensations (including pain), emotional situations, activities and behaviors, scents, sounds, tastes, objects, places, and more. Sexual preferences are always highly subjective and often culturally determined. The problems brought to sex therapy have a wide range, from questions and guilt about one's preferences to coercive paraphilias that in most cases have a compulsive component.

Because the person with atypical sexual behavior, like most everybody else, usually imagines beforehand what is going to happen, hypnotic methods work well. The problems of sexual preference and paraphilias of any kind have been labeled with judgmental terms such as abnormal, perverted, or aberrant sexual behavior in the past. Recently less judgmental words are used, like atypical, as exemplified by the DSM-IV (1994). Patients often complain that they feel like freaks because of their sexual preferences. Even if the person states that he/she wants to change, it is useful to apply the personality parts technique in order to resolve" more positively.

This was the case of Nancy, 27, who announced that she was "anally fixated." When asked to explain what she meant, she described her inability to reach orgasm without prolonged anal stimulation. Her boyfriend had to spend several minutes rubbing her anal sphincter with his fingers, with his tongue and with his penis without anal penetration. Both were most careful about personal hygiene. First the boyfriend had enjoyed it and not objected to what she "my ritual." But after a few weeks of sexual intimacy, he had refused to continue doing it and called her "a weirdo" because she wanted it every time. This issue had become paramount in a relationship that she considered important and serious and that, she was sure, her boyfriend also valued and took very seriously. Nancy was blaming herself for this crisis and wanted to change no matter what. She said, in passing, that she wanted to enjoy fellatio.

With the technique of personality parts she was able to calm down and to view this preference just as such, without adding value judgments. The dialogue between the two main personality *parts* became quite active. The part that enjoyed this—she called it the *baby*—kept repeating, "If this is not bad, why can I not enjoy it?" The other

part—the *grown up*—said “You are fixated, like the baby that you are. Stop being a baby and learn new ways of enjoying yourself,” etc. Then, as if it were coming out of nowhere, Nancy was saying out loud in a definite hypnotic tone, “You were only seven when Louie peed in your mouth.”

The story was complicated. Briefly, Nancy was playing doctor with two boys and another girl. She was the oldest and the others were not yet seven. Louie had an erection and Nancy did not remember how it ended up with his penis in her mouth. Louie seemingly got nervous and started to urinate a little. This disgusted her and made her sick to her stomach. When she was home, she swore to herself that she would never do this again and from that day on she started becoming much more interested in the gluteus maximus, hers and those of other children. Because of this, she discovered pleasurable sensations in the anal sphincter area. She also had “done this” several times with a little girlfriend and many times to herself as an essential aspect of masturbation. She had never asked any previous boyfriend to please her in this way, fearing their disapproval. Because she trusted and cared so much for the current boyfriend, she had mentioned it to him and he had volunteered to do it.

The hypnotic method helped Nancy reach beyond the surface quite quickly and then she mentally rehearsed enjoying not just fellatio but also cunnilingus, which she also had not liked before. This patient clarifies what was mentioned before about not striving to make conscious the unconscious. Hypnosis helped her to stop identifying with the little girl and to assume completely her adult self who rejected returning to the negative feelings of infancy. Paraphrasing Freud, we can say that the ego of adulthood has taken the place of the id of childhood.

Sexual Functioning

Only after understanding the first three rings can we look at sexual functioning, either alone, with another person or with others. This is the area most studied through the years since the landmark research of Masters and Johnson (1966, 1970, 1976). Kaplan (1979) extended and enriched the pioneers’ work and Araoz (1998) concentrated on the hypnotic techniques that are useful in sex therapy. There are five progressive stages in human sexual response: Desire, arousal, foreplay, orgasm, and cognitive processing. To these I add also masturbation because it is a form of sexual functioning and a universal response to sexual desire. Different from sexual preference, functioning focuses on what is normally (when the person has no medical conditions and enjoys good health) to be expected both physiologically and psychologically in the sexual response. In problems of sexual functioning, the experience of the last two decades has shown that therapy comprising *imaginative involvement* (Hilgard, 1970) is consistently more effective than therapy that is mostly purely cognitive. This means, first, a habitual reference to the patient’s spontaneous mental images, both from the past and projections into the future, both negative and positive. Second, *imaginative involvement* also means the constant use of visualization and “vivification,” as in mental rehearsal, to substitute and “correct” the negative images that often lock the person in the unfulfilling or damaging behavior (Araoz, 2003). The five stages of sexual functioning to be discussed are Desire, Arousal, Foreplay, Climax and Processing.

In sexual desire, the extremes of this dimension are *inhibited sexual desire* (ISD) and compulsive or *excessive sexual desire* (ESD). Lack of personal interest (even though it may be accompanied by vast intellectual knowledge in sexual matters),

curiosity, and desire in sex make up ISD. The opposite, excessive sexual interest, desire and activity (satyriasis or nymphomania) fall under ESD.

When the problem is ISD, the therapist asks the patient to identify one past sexual experience that was positive. The purpose is to help the patient “own” this experience as part of the self. If there was no such positive sexual experience, the patient is asked to imagine what a positive and enriching sexual encounter might be for him/herself. If this does not work, he/she is encouraged to think of someone, admired and respected, whom he/she considers a healthy sexual person. The hypnotic technique, a form of mental rehearsal, entering into the sexual fantasy as if it were real, is helpful.

With people of very low sexual desire it is better not to enter directly into the sexual fantasy but rather to proceed slowly, from sensuality to sex. The patient is invited to imagine any physical contact that might be acceptable, even appealing to him/her. Once this is identified, mental rehearsal is centered on it. The following is a sample of the wording used in these cases once the patient is relaxed and centered on the mental image of a physical contact (holding hands, a caress, feeling the other’s physical closeness, etc.). Note that the hypnotic experience starts when relaxation and imaginative involvement are present. The following example is taken from a recorded session:

You can say to yourselves, We are together, touching, feeling the comforting warmth of the other’s body... Put this image in slow motion, without any rush... You feel good... You enjoy this closeness... Allow yourself to feel the love you have for your partner... Your touch expresses that love... That trust... That acceptance... in spite of many imperfections that are part of the human condition... We love each other and are committed to each other... and this physical closeness is one way we have to show it and to remind ourselves of it. ... I want to feel good about my love... Our touching in this way reminds us that we have access to each other’s body... that we belong to each other also in the physical way of pleasure and sex...

The therapist has to be patient and to go at the speed of the patient. If he/she cannot center on the image of physical closeness, the therapist must revert to the initial relaxation through slow breathing, enriched by mental images of what breathing produces in the human body.

Two other points must be kept in mind. For any form of sex therapy to be successful, the two partners have to have a good relationship. This means that they have to be fairly satisfied with each other, that they respect each other, support each other, and are not thinking of romantic or sexual relations with others. If the relationship is not stable, sex therapy is not advised until the relationship problems have been addressed.

The second point is that, at times, the inability to create positive sexual images in one’s own mind is due to very painful and devastating sexual encounters in the past, including sexual abuse. These unresolved issues must be faced in therapy before any genuine sexual interest and desire can be experienced, because in this case the sexual problem is more a symptom of the early traumatic events rather than a problem in its own right.

ESD, on the other hand, can be considered a form of OCD where the object of the obsessive-compulsive behavior is sexual activity. This condition is not treated differently than other OCD cases. As a matter of fact, it becomes more effective when the therapist emphasizes the obsessive thinking about sexual expression or relief, rather than the manifestation of this obsession in the compulsive sexual activity. In these cases the two hypnotic techniques used in this article are also useful. By encouraging the patient to identify with each one of the personality parts at play, the compulsive and the more rational, the patient starts to experience greater control or at least, the possibility of having control over the sexual impulse. While practicing this technique, related issues often spring up, such as beliefs of sexual prowess or attractiveness, feelings of insecurity, fears of sexual feelings or of not being accepted, etc. All these become “sub-menus” requiring therapeutic attention.

When the mental conflict regarding sexual impulsivity has been managed, mental rehearsal allows the patient to get used to denying or delaying his/her impulse, feeling proud and happy about doing it.

Regarding sexual arousal, the second stage of sexual response, the common problem is that the patient is interested in sex and wants to enjoy sexual pleasure but his physical reaction is slow or absent, even though there is no medical reason for this conflict between desire and response. These are referred as *vasocongestive disorders* or VCD, including erectile dysfunctions for men and vaginismus or lack of lubrication for women. The opposite and rarer occurrence is when a person is sexually aroused by the weakest stimulus.

If we understand VCDs, in the negative or most frequent case of sexual arousal problems, as the result of anxiety and tension, we can accept the value of hypnotic relaxation through breathing while focusing on a pleasant mental image, not necessarily sexual at first. This becomes the initial hypnotic work to help the patient obtain a clear experience of natural relaxation. Once they are convinced of their ability to control their anxiety about sexual performance, fear of intimacy, anger, guilt, or other feelings that produce stress, they can move on to the two hypnotic techniques we are presenting in this article. Obviously, the awareness of these feelings may necessitate working on them therapeutically before any sex therapy is attempted.

The male patient can imagine himself having all the manifestations of sexual arousal in a relaxed state and without any distracting thoughts or feelings, identifying his “strong self” as being able to do it and his “weak self” as distracting him from sex. Slowly he can enjoy the mental rehearsal until he is confident enough about his reaction in the real situation.

The female patient with either psychogenic vaginismus or deficient vaginal lubrication is invited to recognize the mental images she is using (without conscious awareness) to “explain” her condition. In deep relaxation, she is asked to find metaphors and similes, not reasons, for the VCD. Once she is aware of the negative imagery at work in her condition, she can start changing it. For instance, a simple device is to request that she notice what color seems to predominate in her mental imagery. As she continues to breathe, she is instructed to think of life, energy and positivism on inhaling and of getting rid of things she does not need in her life while exhaling. At the same time she is made aware of any color that may come to mind while she is breathing and how it changes with inhalation and exhalation. If the color does not appear spontaneously, she may choose a color and imagine that it becomes brighter or more beautiful as she

breathes in fresh air. This color can become her healing and safe environment. Obviously this hypnotic technique, colorization, may be applied with many patients in different situations (Napier, 1990) but in problems of sexual arousal the gloom of the problem changes into something more cheerful by adding this imaginative detail.

J.C. was a 29-year-old college graduate and the manager of a retail store where many of the customers were young, attractive, affluent and educated women. He enjoyed moderate pornography with normal and positive sexual reaction. He had no difficulty approaching women and getting dates with them. However, when he was alone with a woman, especially when there was any physical intimacy, he became “numb” and his penis was “dead.” Because of this, he had been in bed with a woman only four times in his entire life, even though he started dating at 15.

When he connected to his personality parts in therapy, he discovered one that looked very much like his mother—in fact, he did not know whether this side of his personality was male or female—who kept saying “what I think my mother would say to me about sex.” What spontaneously came up included many negative, insulting, and condemning statements referring to sex—and more specifically sexual pleasure—as something dirty, animalistic, base, sinful, and unworthy of a decent person. Therapy helped him center on his “genuine and mature self” who vehemently refused to accept his mother’s values and views on sex. This mental exercise went on for several weeks, during which he made important changes in his life like abstaining from pornography. All along the gloomy colors he had used in describing the maternal negative injunctions were slowly changed to bright, cheerful, and happy ones.

The mental rehearsal included some of the women he was dating and the therapist added the prescription to practice this in private but not to rush to any form of sexual climax when he became aroused. During this mind activity, the positive colors he had used in the other practice were added. Desire became arousal after less than 2 months in every other week sessions of sex hypnotherapy.

The third stage, sexual foreplay, allows humans to “regress in the service of the ego” (Kris, 1952) by innocently and inhibitedly playing with each other, feeling safe, cared for, and loved. Kaplan (1979) called it “regression in the service of pleasure.” The term of lovemaking originates in this stage of human sexual functioning that other cultures, especially in the Orient (like the popular Kama Sutra), have emphasized in great detail.

Because of this, problems in the foreplay stage often indicate one of these two conditions, either ignorance and poor sex education, or boredom, lack of emotional excitement, distracting thoughts unrelated to the sexual situation. Clients who believe that foreplay is for the young, not for long lasting couples, fall in the category of ignorance. In this group one finds patients, mostly married, middle-aged men, who want to get to sexual intercourse quickly, bypassing foreplay and considering it a loss of time. They disregard any notion of gourmet sex. In the second category are the people who engage in sex without great interest and no enthusiasm, who do it mostly or only to keep the partner from complaining. In these two cases there are usually serious problems in the relationship itself and couples’ therapy per se, rather than sex therapy, is indicated.

Nevertheless, some patients suffer from sexual foreplay disorder even though they have a healthy attitude towards sex, they enjoy a good relationship with their

partner and they respond with normal arousal to sexual stimuli. But when it comes to enjoying sex, their mind wanders and they are distracted with other thoughts. In this case, our two hypnotherapy techniques are also useful. First, the personality part that wants to enjoy sex is heard and its arguments and reasons for enjoying sex are noted. Then the patient is taught to mentally rehearse what good sex can be, putting the mental images in slow motion in order to get into every detail of a wonderful sexual encounter. Repetition here, like in most hypnotherapeutic instances, is recommended in private.

To summarize the therapeutic sequence, I am fond of the Spanish word *vivencia* that encapsulates what English requires many words to describe. It means “a vivid and detailed mental experience involving any and all the inner senses, to the degree that it is lived in one’s mind as if it were real and happening in the present” (Araoz & Goldin, 2004). Therefore, to improve problems in sexual foreplay, the patient is helped to have a *vivencia* of a very enjoyable sexual experience. He/she is asked to repeat it many times in private until it becomes so natural that it is expected to happen that way when the patient is sexually involved with his/her partner.

A couple married for many years, with three children in their late 20’s and early 30’s, came to therapy for this problem. The 54-year-old husband agreed with the wife’s complaints but added that she had to live in the real world. What she wanted was for the young and her real problem was to refuse to grow up at the age of 50. The therapist was a man. He reminded them that as older people can take great pleasure in food, so too in sex. The husband wanted to please his wife and disliked seeing her so unhappy about their lovemaking. The therapist invited the husband to give this “method” a good try and taught him the two techniques herein described. The two parts of the husband personality turned out to be the one who was ashamed of acting sexually like his children, and the part that enjoyed sexual pleasure and felt that he too deserved to experience it with his wife.

In mental rehearsal, he desensitized himself to the embarrassing and guilty feelings and repeated to himself that sexual pleasure was good and that he wanted to enjoy it even though he was not young anymore.

Sexual climax or orgasm is the healthy, normal, inevitable, outcome of the three preceding stages. The inability to reach this physiological conclusion in the absence of any medical reason is frequently a manifestation of unresolved problems in the relationship. It is always useful to ask the couple for their explanation of the difficulty. “This is happening to me because ...” However, this approach works better when the therapist asks them not to answer right away but to think for a moment about the lack of orgasm and to notice any mental images or memories that come to mind. When their “explanation” becomes too intellectual and rational, they are steered to think of a comparison, analogy, or metaphor for their problem. If this does not come up promptly, the therapist asks if they would accept to compare their problem to whatever analogical image comes to the mind of the therapist. Once the patients accept the possibility of the analogy proposed to them, the hypnotic work starts with the visualization of the analogical image and continues with the transformation of negative elements in the analogical representation into positive and constructive ones. Here is an example.

The patient says that his lack of orgasm is “like being out in space.” The visualization of being in space includes the amount of light, the destination intended, the sensation inside of the space suit, the feeling of weightlessness, etc., and the

possible application of these images to the patient's sexual situation. Note that no interpretation is offered because the patient usually obtains practical insights about the problem.

Again the personality part that wants to reach orgasms and the part that seems to short-circuit it are identified and the motives of each, as well as their intent in pursuing each course of action are paid attention to. Mark, dating the same woman for almost 7 years, heard one part of his personality saying that he could not reach orgasm until he was absolutely sure that he cared for her. The other part responded with scorn and mockery, ridiculing all the good times Mark and his date had during all those years and reminding him of the religious, anti-sex, brainwashing he had been subjected to as a child and young adolescent, just before he left his original religious affiliation.

Mental rehearsal, as in the previous examples, completed the hypnotherapeutic work, allowing Mark to mentally experience and see himself having an orgasm while ignoring the irrational voice of the past.

If the problem is lack of sensitivity of one partner to the non-orgasmic other, couples' therapy approaches are needed before the sexual problem per se is addressed.

The final, quasi-stage is mental processing. I refer to it as a "quasi-stage" because the mental assessment of the situation is always present in normal people, from the moment sexual desire is experienced, following into each one of the following stages. Confirming this mental activity during sexual functioning, Walen (1980) suggests evaluation points in the sexual response cycle. Further attention to this mental activity during the entire sexual cycle allows us to claim that the mental activity going on during sex and, especially after it is finished, is very rich. It consists of both mental images and statements, of memories going back to the earliest awareness of one's sexuality and those that are more recent. But because most often people assess their sexual experience after it has happened, I like to call it a quasi stage. In the new trend of positive psychology (Seligman, 2000), it is imperative that the sex therapist encourage patients to evaluate themselves with optimism. Ellis' (1962) famous condemnations of the "should," in harmony with Horney's (1972) tyranny of the should concept, are helpful in sex therapy for helping patients realize their negativism and for focusing more on the positive aspects of the sexual situation.

In this quasi stage the hypnotic technique of personality parts is also useful for patients to realize the dichotomy in their thinking. Next, mental rehearsal helps them get into the habit of positive thinking, if we accept Seligman's (1990) research showing that optimism can be learned. A simple hypnotic method is to guide the patient through an entire day of optimistic living.

Sexual Mores

Finally, a very important "ring" of human sexuality is what one's culture and historical moment allow or forbid, encourage, or discourage in the field of sexual behavior. This refers to the expectations that society has for men and women. These come from the rules established by the economic, political, ethnic, family, social, and religious values and roles. These and other factors affect the expectations that each person has for oneself and for others because of their sex (Barkley & Mosher, 1995; Williams & Ellison, 1996; Zamora-Hernandez & Patterson, 1996).

Therapists often encounter patients with problems of sexual role rebellion who want to express their nonconformity in dress, makeup, and customs. Like in all cases of

ambivalence, those who are uncomfortable about their rebellion can be helped by the use of the two techniques we have been studying. The progression is always the same because an existential ambivalence is always present in the voluntary patient who wants to change something in him/herself.

First, the patient is encouraged to identify with the personality part that wants or practice something that another personality part seems to object to. Then this latter part is brought up simply by stating something like, "Allow yourself to be now the other part. Take a moment to get into that side of yourself... Now, listen to what this part is saying about this issue." Second, the patient is invited to mentally rehearse the behavior that was rejected before. This is repeated until the patient senses that s/he can now truly choose one or the other path of action.

Conclusion

Because the new hypnosis is the quintessence of client-centeredness (Araoz, 1985), it accommodates respectfully to the patient, deliberately producing practical changes rather quickly. As indicated earlier, there are many different ways, so called techniques, to go about it. In order to facilitate the new hypnotic approach for those who are not familiar with it, here I have concentrated on two of these techniques, although others have been mentioned in passing. This is the case with colorization in sexual arousal or with the therapeutic use of the patients' imaginative analogies for their lack of climax, just to mention two examples.

The new hypnosis approach in sex therapy helps the clinician to assist individuals and couples in each of the five levels of human sexuality. It gives patients a new inner awareness enabling them to manage their sexuality from within, naturally and without excessive effort, with greater choice and freedom than before. If changes have to be made, it allows patients to get ready for the changes by becoming fully ready for them thanks to the familiarity and comfort with the new attitudes or behaviors acquired by means of mental rehearsal.

Even though this article is limited to sexual dysfunctions, other psychotherapists who do not use "hypnosis" regularly may find value in this method. Unlike the traditional practice of hypnosis, here the emphasis is on the spontaneous imaginative productions of the patient, working more with mental images and metaphors than with logic, argument, and reason. The therapeutic question is "What images come to mind?" rather than, "What do you think (or feel) about this?"

As hinted before when initially discussing the different stages of sexual response, it seems that the "common factors" of successful psychotherapy will have to include imaginative involvement, as the early research of Cautela (1966) started to indicate almost 40 years ago and the current data (e.g. Duncan, Hubble & Miller, 1997) demonstrate.

References

- American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders (4th ed.)* Washington, DC: American Psychiatric Association.
- Araoz, D.L. (1985). The new hypnosis: The quintessence of client-centeredness. In *Ericksonian psychotherapy (Vol. 1: Structures)*. New York: Brunner/Mazel.

- Araoz, D.L. (1995). *The new hypnosis*. Northvale, NJ: Jason Aronson. (Original publication 1985).
- Araoz, D.L. (1998). *The new hypnosis in sex therapy*. Northvale, NJ: Jason Aronson. (Original publication 1982).
- Araoz, D.L. & Goldin, E. (2004). The importance of “vivencia” in the hypnotic treatment of sexual dysfunctions. *Australian Journal of Clinical Hypnotherapy and Hypnosis*, 25, 65-76.
- Araoz, D.L., Burte, J., & Goldin, E. (2001). Sexual hypnotherapy for couples and family counselors. *The Family Journal: Counseling and Therapy for Couples and Families*, 9, 75-81.
- Araoz, D.L. & Kalinsky, E. (1987). In *Integrating sex and marital therapy: A clinical guide*, by G.R. Weeks & L Hof, Eds. New York: Brunner/Mazel.
- Bandura, A. (1969). *Principles of behavior modification*. New York: Holt, Rinehart & Winston.
- Barkley, R. & Mosher, E. (1995). Sexuality and Hispanic culture: Counseling with children and their parents. *Journal of Sex Education & Therapy*, 21, 255-267.
- Bell, A.P., Weinberg, M.S., & Hammersmith, S.K. (1981). *Sexual preference: Its development in men and women*. Bloomington, IN: Indiana University Press.
- Benjamin, M.H. (1966). *The transsexual phenomenon*. New York: Julian Press.
- Blanchard, R., Legault, S., & Lindsay, W. (1987). Vaginoplasty outcome in male-to-female transsexuals. *Journal of Sex and Marital Therapy*, 13, 265-275.
- Brancoft, I. (2003). Can sexual orientation change? A long-running saga. *Archives of Sexual Behavior*, 32, 419-421.
- Carrese, M.A. & Araoz, D.L. (1998). Self-hypnosis in sexual functioning. *Australian Journal of Clinical Hypnotherapy & Hypnosis*, 19, 41-48.
- Camino, A. & Gibernau, M. (1997). Hipnosis ericksoniana: Aplicaciones en psicoterapia [Ericksonian hypnosis: Applications in psychotherapy]. *Revista de Psicoterapia*, 8, 2-20.
- Cautela, J. (1966). Treatment of compulsive behavior by covert sensitization. *Psychological Record*, 16, 33-41.
- Cole, C., O'Boyle, M., Emory, L., & Meyer, W. (1997). Comorbidity of gender dysphoria and other major psychiatric diagnoses. *Archives of Sexual Behavior*, 26, 13-26.
- Crooks, R. & Baur, K. (1999). *Our sexuality* (7th.Ed.). Pacific Grove, CA: Brooks/Cole.
- Drescher, J. (1998). *Psychoanalytical therapy and the gay man*. Hillside, NJ: The Analytic Press.
- Duncan, B.L., Hubble, M.A., & Millar, S.D. (1997). *Psychotherapy with impossible cases: Efficient treatment of therapy veterans*. New York: Norton.
- Ellis, A. (1962). *Reason and emotion in psychotherapy*. New York: Stuart.
- Erickson, M.H., Rossi, E.L., & Rossi, S.I. (1976). *Hypnotic realities: The induction of clinical hypnosis and forms of indirect suggestion*. New York: Irvington.
- Fausto-Sterling, A. (1985). *Myths of gender: Biological theories about women and men*. New York: Basic Books.
- Fausto-Sterling, A. (1993). The five sexes: Why male and female are not enough. *The Sciences*, March/April, pp. 20-24.
- Grand, S. (2003). Unsexed and ungendered bodies: The violated self. *Studies in Gender*

and Sexuality, 4, 313-341.

- Green, R. & Fleming, D.T. (1990). Transsexual surgery follow-up: Status in the 1990s. *Annual Review of Sex Research*, 1, 163-174.
- Godin, J. (1992). Traditional hypnosis and new hypnosis: Rupture or continuity? *Australian Journal of Clinical Hypnotherapy and Hypnosis*, 13, 57-68.
- Hamer, D.H. (1993.) A linkage between DNA markers on the X chromosome and male sexual orientation. *Science*, 261, 321-327.
- Hilgard, J. (1970). *Personality and hypnosis: A study of imaginative involvement*. Chicago: University of Chicago Press.
- Horney, K. (1972). *Collected writings*. New York: W.W. Norton.
- Kaplan, H.S. (1979). *Disorders of sexual desire*. New York: Brunner/Mazel.
- Kris, E. (1952). *Psychoanalytic explorations in art*. New York: International Universities Press (Original publication 1934).
- LeVay, S. (1991). A difference in hypothalamic structure between heterosexual and homosexual men. *Science*, 253, 1034-1037.
- LeVay, S. (1993). *The sexual brain*. Cambridge, MA: MIT Press.
- Masters, W. & Johnson, V. (1966). *Human sexual response*. Boston: Little, Brown.
- Masters, W. & Johnson, V. (1970). *Human sexual inadequacy*. Boston: Little, Brown.
- Masters, W. & Johnson, V. (1976). *The pleasure bond*. New York: Bantam Books.
- Money, J. & Wiedeking, C. (1980). Gender identity/role: normal differentiation and its transpositions. In B.B. Wolman & J. Money (Eds.) *Handbook of human sexuality*. New York: W.W. Norton.
- Morrow, S.L. & Beckslead, A.L. (2004). Impossible dreams, impossible choices. *The Counseling Psychologist*, 32, 778-785.
- Napier, N.J. (1990). *Recreating yourself: Help for adult children of dysfunctional families*. New York: W.W. Norton.
- Seligman, M.E.P. (1990). *Learned optimism*. New York: Pocket Books (Simon & Schuster)
- Seligman, M.E.P. (1993). *What you can change . . . and what you can't*. New York: Fawcett Columbine.
- Seligman, M.E.P. (2000). Positive psychology: An introduction. *American Psychologist (Special issue on happiness, excellence and optimal human functioning)* 55, 5-14
- Walen, S. (1980). Cognitive factors in sexual behavior. *Journal of Sex and Marital Therapy*, 6, 87-101.
- Watkins, J. & Watkins, L.H. (1997). *Ego states: Theory and practice*. New York: Norton.
- Weitzenhoffer, A.M. (2000). *The practice of hypnotism (2nd Ed.)*. New York: John Wiley & Sons, Inc.
- Wiederman, M.W. (1998). The state of theory in sex therapy. *Journal of Sex Research*, 35, 88-100.
- Williams, E. & Ellison, F. (1996). Culturally informed social work practice with American Indian clients: Guidelines for non-Indian social workers. *Journal of the National Association of Social Workers*, 41, 147-151.
- Zamora-Hernandez, C. & Patterson, D. (1996). Homosexually active Latino men: Issues for social work practice. In J. Longres (Ed.) *Men of Color*. New York: Harrington Park Press.