Application of Hypnosis in Sex Therapy

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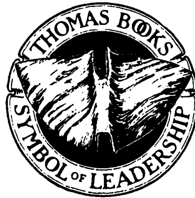

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INTRODUCTION

IN 1977, I invited Doctor Hugo Beigel to share my program, "Some Uses of Hypnosis in Sex Therapy," at the annual meeting of the American Association of Sex Educators, Counselors, and Therapists (AASECT) in San Francisco. This was a happy collaboration in which a master sexologist and hypnotherapist added depth and other dimensions to the program.

Later in a typical lobby conversation, I told him that I was in the early stages of writing a basic book on the uses of hypnosis of sex therapy. I explained that, although my recent questionnaire survey of professional people who use hypnosis in sex therapy made it clear that there is some appreciation of the possibilities of the technique, a surprisingly effective resource is generally being neglected. Moreover, I pointed out, I had attended meetings devoted to the subject, including his own workshops, and had tended to be amazed at the usual limited sophistication of the therapists involved. For example, after a provocative presentation, the only response of the audience might be to request a demonstration of how to perform routine hypnotic induction! It had seemed to me that a basic book might help to move education in this area to a higher level. I finished by asking him whether he might be interested in collaborating with me in such a venture, himself as senior author, of course.

His answer was an immediate and enthusiastic "yes." It was evidently one of those remarkable situations in which the time was just right for the proposal. He had published numerous articles and made numerous presentations on the subject, and as long time editor of the *Journal of Sex Research* of the Society for the Scientific Study of Sex (SSSS) (he was also a cofounder of that organization) had seen to it that hypnosis research had not been ignored. Still, it had evidently just not crossed his mind to do a book wedding his favorite subjects, hypnosis and sex.

At about this point in our discussion we enjoyed an unexpected, really light-hearted, laugh together. He smiled and said, "We'd probably better move right along with this. I'm eighty-four years old, you know." No, I hadn't known. I'd have guessed him twenty years younger, somewhat closer to my own fifty-six. "Well," I answered,

"we make quite a pair. I couldn't hope to buy a policy from any life insurance company in the country!" We laughed, shook hands, and the deal was made. I think we were both quite confident that if one of us were not able to see the project through to successful completion, the other could be counted upon to do so. We got to work on it almost immediately.

Hugo had worked extremely hard on the manuscript for over a year when he suffered his first stroke. For a time there was reason to hope for recovery, but the degenerative process closed in and he died a few months later. In due course, Greta, his lovely wife of well over half a century, made possible the assembling of his manuscript and notes. It has been my task — and a most difficult task it has been — to pull his, my, and our contributors' work together into a meaningful whole. I believe that Hugo would be reasonably happy with it as it now stands.

Be it understood at the outset that this is primarily Hugo Beigel's book. He played the major role in designing the approach, and most of the cases presented are from his files. As I told him, I'll take a back seat to few people when it comes to knowledge of this subject; but the fact remains that he probably dealt with more cases in an average couple of years of his half-century plus career than I have in my entire career. (I am known mainly, in the hypnotic field, for my unique, controlled research on the effects of hypnotic suggestions upon muscular performance and only secondarily for my efforts to encourage the use of hypnosis in sex therapy.)

Following are some of the thoughts that I am confident Hugo Beigel wanted included in this Introduction.

> The intensive research that has gone on during the last two decades in the field of human sexuality has resulted not only in immensely important insights, acknowledgement of justified needs, assertion of equal rights of both sexes in the intimate relationship, but also in vastly greater knowledge of the causes of sexual dysfunctions and deviations, and in more and more successful attempts to remedy such disorders.
>
> In consequence of the advances, a new specialization has emerged in the healing profession: various methods for removing unwelcome impediments to a satisfactory and socially acceptable sex life.
>
> Naturally, the modification of warped feelings and faulty behavior could at first be approached only by traditional therapeutic means. Yet, for all their endeavors at adjustment to the novel situation and in spite of some undisputed favorable results, the traditional methods simply did not measure up to the growing and more

diversified demands. For example: one approach costs far too much in time and money to meet the popular demand; another mobilized solely the conscious mind while the inimical forces sat fortified in the inaccessible unconscious depth, and therapy, therefore, was limited to the removal of easily uprooted symptoms; still another confined itself to couples — in the face of the fact that over fifty years of experience suggests that many individuals desiring help will not or cannot bring in a partner (As the moods of these days change, more and more individual males and females are seeking sexual help).

This state of affairs determines the purpose of our book. It is to make qualified professionals, working therapeutically with people who are afflicted with sexual problems, or students, intending to join the profession, familiar with the possibilities of hypnotism. Modern hypnotism is a system that, combined with psychoanalysis, behaviorism, *or any other psychological school of thought,* enriches and expands the accomplishments of sex therapy.

The legitimate domain of sex therapy comprises all non-organically caused sexual disorders. Their range is wide. It includes all erotopathy, sexual dysfunction, deviations, inhibited and excessive sexuality, sexual peculiarities, idiosyncrasies, anxieties and discomfort linked to the sexual apparatus, sexual functioning, and sexogenic psychosomatic phenomena.

DYSFUNCTIONS. These include, frigidity, sexual anesthesia, anorgasmia, vaginismus, impotentia erigendi, impotentia coeundi, impotentia ejaculandi, selective impotence, premature ejaculation, retarded ejaculation, gynophobia, peccatiphobia, and coitophobia.

DEVIATIONS. Deviations is a controversial term. In this context, it does not mean any sort of sexual activity except the "missionary position" for procreative intention, but compulsive psychodynamically conditioned sexual substitutes for heterosexual desire. For instance: homosexuality, transvestism, erotic cisvestism, transsexuality, scoptophilia, exhibitionism, masochism, sadism, nymphomania, satyriasis, compulsive promiscuity, incest, pederasty, pedophilia, zooerasty, zoolagnia, addictive masturbation, anorexia nervosa, and rape.

INHIBITED AND EXCESSIVE SEXUALITY. These include psychological inability to find or approach a partner, inhibition to unrobe, aversion to being touched, inhibitions against sex play, inhibitions against change of position, and excessive masturbation.

PECULIARITIES AND IDIOSYNCRASIES. These include fetishism, coprophilia, coprolalia, coprophagia, erotic tics and compulsive

gestures, frottage, obsessive sexual thoughts, urolagnia, gerontophilia, virgophilia, enema addiction, pyrolagnia, pyromania, pectillomania, and sexual soliloquy.

DISCOMFORT AND ANXIETIES LINKED TO SEXUAL FUNCTIONS AND GENITALIA. These include fear of defloration, of pregnancy, of venereal disease, of being a homosexual, of having too small a penis, of looking feminine, etc., anxieties related to contraception, unorganic dyspareunia, unjustified menstrual pain or menopausal discomforts, postmastectomy depression, and postcoronary anxieties, osphresiophobia.

OCCASIONALLY SEX-LINKED PHENOMENA. These include excessive blushing, erythema, obesity, gastric intestinal responses, various hysterical symptoms, pseudocyesis, fainting at orgasm, etc.

The list is most probably not complete, for it contains only those sexual or sex-linked disorders that hypnotherapy has been ameliorative or totally successful in treating and those that have come to the senior author's attention. Even so, however, it contains more authenticated items than any other sex therapy can point to, especially if its representatives must admit that for single males they can often do no more than provide counseling (Kaplan, 1974; Beigel, 1975).

It is true that fewer so-called deviants seek therapy than even a few years ago. The American Psychiatric Association has removed homosexuality from its list of mental illnesses, several states have rightly struck down laws by which this sexual predilection was punished, and some have instituted laws against discrimination in housing and employment on the grounds of this orientation. Other groups of "deviants," encouraged by these steps are hoping for decriminalization of their predilection. (However a powerful, national backlash is now pushing this entire situation into question.)

Despite these facts, many people still feel uncomfortable and come for therapy. They may be the ones who still uphold their punitive laws, or they may be aware that, whatever the law, a majority of the population barely tolerates them as neighbors or coworkers. So they wish to rid themselves of what they have come to consider a millstone around their necks.

In passing, we may note that in hypnotherapy, deconditioning is used in these cases. But in addition, there are ways to recondition or redirect the patient toward the possibility of a heterosexual relationship.

A couple of brief examples will illustrate still another possible, perhaps unexpected, use of hypnosis in therapy. A psychoanalyst,

an experienced and efficient man, referred one of his female patients. She had been treated by him for three years. Progress had been made, but her problem had not yielded. Neither she nor he wanted to give up, yet both felt the relationship had gone stale. The patient was unable to produce new relevant material.

In the first sessions the old material was reviewed. From then on she was hypnotized every session for about half the time, while the other half was devoted to the discussion of the material that had surfaced. This material was of such quantity and quality that the referring psychiatrist was, as he wrote in an enthusiastic letter, overwhelmed. With its help, the case was successfully terminated three months later to the satisfaction of all concerned.

A similar episode led the referring physician to comment, "These few sessions have worked magic on the patient."

But there is no magic in hypnotism, as we routinely explain to every client who expects treatment with hypnosis.

What then is the strange power of hypnotism?

All therapies for functional disorders address themselves to the mind. Some therapies appeal to the patient's rationality, and some try to penetrate the fogginess of the unconscious. Even counseling and physical conditioning ultimately endeavor to influence thinking, emotions, and thus behavior. Hypnotism is special in this respect; it is able to put the mind in a state in which it is most receptive, in which suggestions can be made to appear as the subject's own thoughts, feelings, and decisions. Fantasies and dreams, pertinent to a conflict emerge and lead to unverbalized insights. As must be the aim in all instances of serious inner discord, hypnotherapeutic treatment is most likely to accomplish the integration of the conscious and the unconscious mind.

Although there is no universally accepted theory of hypnotism, the serious students of this still insufficiently explained phenomenon are agreed that in the thus provoked "altered" state the mental defense garrisons are more scantily armed than in the waking state and, therefore, that emotional energies can be more effectively focussed on the momentary task. The parts of the brain responsible for retention of experiences can be activated and so envigorated that seemingly forgotten memories are capable of breaking through the cordon of castellated defenses and yield essential material to the conscious mind unsealing motivations, fears, and banned wishes that the patient does not want to acknowledge and therefore cannot reveal to the therapist in the waking state. In addition, they can be shelved again if their revelation to the patient

seems untimely. Affective imagery may leave traces so strong that the patient becomes able to omit actions or thoughts to which before he had been compelled or to undertake what before he never trusted himself to venture. Underdeveloped sensations can be intensified. Any of these possibilities are significant for the alleviation of psychogenic disturbances. Yet they may become equally important as adjuncts in physical ailments for which the physicians' traditional equipment and training fails to indicate the solution. Roentgen x-rays expose some secrets inside the body. They are useless, however, in detecting the source of a pain if no visible traces are present.

Twenty-five years ago, Jean Bordeux (1953), Ph.D., psychoanalyst, wrote me a letter in response to an article I had published (Beigel, 1953). In this letter he deplored the ignorance that hampered a more rapid progress of the knowledge of hypnosis.

> Even in daily consultation practice, proper use of hypnoanalysis or hypnotherapy achieves results which are almost impossible to reach in other ways.
>
> A few days ago, a general practice M.D. referred a female patient, married, three children, apparently happy in her life, aged thirty-six, suffering from excruciatingly sharp pains in the coccyx area. She had been a patient of this M.D. for twenty years and so he knew her thoroughly. X rays showed no organic trouble. The pain had come abruptly about a week before referral to me.
>
> She was a splendid subject. Using dissociational methods, the direct query was made, "Càn we learn something about the original cause of the pain?"
>
> "Yes."
>
> "Let's place this person in the situation in which the pain was originally felt."
>
> Patient began writhing, weeping, crying, "Don't hit me, don't hit me."
>
> Inquiry (as suggestions were made that she would not feel the pain temporarily) revealed that at the age of six, her father had beaten her. We again went carefully through the incident as she was regressed, then brought her back to the present and asked the dissociated self a simple question, "This beating and kicking occurred thirty years ago; why should the person now feel it?"
>
> "A new neighbor moved into a house nearby, just down the street. He resembles her father greatly. This brought the old resentment which in turn brought up the pain."
>
> All this was then discussed with (the) entranced patient. Awakened, it was discussed again. Then, quite casually, I remarked, "By the way, how is the back feeling?"
>
> Patient, puzzled, "Why . . . why . . . well, Doc. It's funny, but I don't have any pain now." Since then, patient has been well.

"Dissociation" is but one of several methods that have been developed over the years. These methods have proven to be therapeutically effective. Briefly summarized they are the following: direct suggestion; covert suggestion; ideational conditioning and reconditioning; role playing; guided, free, and open-end imagery; scene visualization; cognitive and emotional reeducation; age regression; dynamic regression; age progression and age projection; symptom substitution; symptom removal; crystal gazing; automatic writing; automatic drawing; dream production; dream revival; retrieval of forgotten dreams or of forgotten parts of a dream; close-up of dream details; dream interpretation in the trance state; posthypnotic dreaming; amnesia; undoing of natural or hypnotic amnesia; posthypnotic suggestion; revivification; dissociation; depersonalization; integration of conscious and unconscious strivings.

Some of the procedures have subdivisions, some overlap in small details. As many of them as possible will be demonstrated as they have been applied to clinical cases involving sex.

In spite of concrete evidence of a great deal of progress in recent decades in our learning to use hypnosis as a means of stimulating dormant energies of the mind to fight or counterbalance health-hostile forces, we cannot yet chart the scope of its potentialities. On the other hand, its confirmed achievements are sufficient to have won it a place in modern medicine, dentistry, and psychotherapy. In the former fields it will doubtless continue to be an adjunct, but in psychotherapy, including sex therapy, its role now seems assured and likely to become eminent. Indeed, in sexual disorders, the majority of which are not of physiological origin, hypnosis may usually be the proper choice, perhaps in conjunction with other favored media. It is, of course, our hope that our work will hasten the day when hypnosis will assume what we believe is its rightful position in the overall therapeutic picture.

The survey questionnaire of those using hypnosis in sex therapy that I conducted in preparation for my 1977 AASECT presentation, was very revealing in various ways. In the first place, what a time I had finding individuals doing sex therapy in this way! First, I contacted all of those I knew and asked each of them to provide names of those they knew. It became an international search. Later on, Doctor Beigel even advertised for people in the Journal of the Society for Clinical and Experimental Hypnosis. Our efforts produced less than fifty in the *international* scene, surely a very incomplete list, we hope, but the best we could do. Some interesting findings were as follows:

1. All of these therapists were enthusiastic about the effectiveness of

hypnosis as they had used it. They had treated an extremely wide range of conditions, as Doctor Beigel suggests is very possible. However, the great majority of problems were those that have been identified by such people as Al Ellis and Masters and Johnson as most common: lack of responsiveness ("frigidity") in the female and "impotency" in the male. It is for this reason that several chapters of this book are devoted to these subjects as dealt with by different therapists.

2. As a predominately research hypnotist, I have always been interested in how much importance clinical workers attach to depth of trance in their work. Of course, in research work it is necessary to be able to state just what trance level was involved in specific testing, perhaps so as to be able to compare performance at different levels, to constitute a control condition, perhaps to be able to assure posthypnotic amnesia, or what not. In contrast, my own clinical experience was more in line with that reported in much psychotherapeutic literature and by various clinicians: generally, the usually laborious, step-by-step progression to deep trance levels is simply not necessary.

So it was in the great majority of responses to my questionnaire. Therapists stated: "It doesn't seem to matter," "Clients tend to adjust their trance level as the situation requires," "After trance induction and a certain amount of deepening, they're ready to go."

On the other hand, some made the point that the deeper the trance, the more likely that suggestions are going to be effective. (I suspect that with equal time and effort expended, if workers were to have a choice between light and deep trance to work with, they'd opt for deep.) Of course, people like Doctor Freytag (Chapter 4), some of whose research-treatment procedures tend to require deep trance criteria, have no choice but to specify that level as essential.

3. Although a few respondents identified certain groups, such as psychotics, as unsuited for hypnosis, generally speaking, no danger was seen in using hypnosis in sex therapy — assuming that the therapist is a qualified professional person. Being "qualified" was seen by most as meeting qualification requirements in both sex therapy and hypnotic organizations, such as AASECT and the Society for Clinical and Experimental Hypnosis, or the American Society of Clinical Hypnosis.

Another special value of the survey was in helping identify individuals who not only use hypnosis in sex therapy, but who also had written on various aspects of the subject or would be willing to prepare material specifically for this book. We are indeed grateful to those who contributed one or more chapters to this book. In some cases these add original dimensions to the coverage. In others, their

chief function is to demonstrate how different therapists approach the same kinds of problems in different people.

My many communications with Hugo Beigel lead me to believe that I speak for us both in concluding this Introduction as follows:

This book is addressed not only to professionals who practice sex therapy and students who plan to do so. It is addressed also, in a way, to the millions of people who, for one reason or another, cannot find in sex the joy they had expected and is, indeed, their birthright. Our experience and that of our distinguished contributors convinces us that hypnosis provides a major means whereby large numbers of people can be very efficiently helped.

Warren R. Johnson

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Application of Hypnosis in Sex Therapy

PART ONE

Exploration

Chapter 1

THE INITIAL INTERVIEW

THE initial interview is the first step in the exploration of the patient's sexual trouble. It aims at gaining an at least approximate picture of the disturbance in the framework of his or her personality, health, emotional and social background, sexual experiences, and response to hypnosis.

When the patient appears the first time in the therapist's office, the latter usually knows no more than name, address, sex, age, marital status, and occupation and the source of referral.

The atmosphere of the first interview should convey permissiveness and a warm and friendly interest, the tone is serious but informal, confident but not condescending, and participative but not commiserating. Patients are usually more apprehensive about discussing matters relating to their sexuality than about enumerating symptoms and feelings of a "real" and possibly dangerous illness. They are not ashamed of the latter, but a sexual disorder appears to many as a disreputable secret. Indeed it often is concealed even from the mate or the sexual partner, and worry about it strikes them as utterly undignified. And sexual "deviants" would not seek therapy unless they have come to loath or to fear their divergent inclinations. In states where unusual sexual practices are still legally punishable, such loathing and fear are likely to be aggravated and make not only learning the full truth, but also therapy more difficult. Kroger's (1976) remark about patients coming for therapy in general — "The presence of fear increases the defenses and causes the patient to withdraw, thus concealing his anxiety and need for help" — has particular validity for the sex-troubled client.

Consequently it is especially important to put patients at ease before the inquiry about symptoms and about the motive for the visit begins.

Needless to say, judgmental responses or moralizing by the therapist is totally out of place, as is ridiculing of the patient's theories to explain the problem, e.g., youthful masturbation causing present dysfunction.

Rather, therapists should listen, apparently with complete absorption, to whining as well as to swaggering. They should encourage

continuation with an occasional nod and not interrupt, but take silent note of points that in their opinion should be clarified and further investigated either later in the session or another time under hypnosis. After all, they depend mainly on verbalizations for everything they need to know about a patient's mental make-up; they cannot, as the physician can, draw on urine tests, encephalograms, or x rays to get additional information.

However, they do not only listen. At the same time they carefully observe gestures, hesitations, contradictions and asides, raising and lowering of the voice, signs of excitation, bragging, anger, self-persiflage, accusations of other people, and similar signs of emotional agitation. These histrionics are likely to divulge something about the patients that is worth knowing.

For example, Ms. H., a young woman, assumed a theatrical pose while making a long prelude to the admission of anorgasmia. "I am completely liberated," she proclaimed. This ostensible liberation was to justify intercourse with half a dozen men. It seems that her chief lover had persuaded her with a promise of marriage as soon as she proved to be no longer prudish. Her amateurish play acting served the more important function of quelling her guilt feelings and eclipsing the conflict between the murky sex life to which she had committed herself and the demands of her strict religious upbringing. But all her rationalizations apparently did not silence the rebellious conscience. She paid for the disregard of deeply ingrained feelings — among them her father's longed-for love — with the loss of sexual sensations. (The first tentative diagnosis was confirmed in the following exploratory session under hypnosis. The bombastic freedom fighter shrank to a whimpering child, begging her father to love her again now that her sins had been obliterated by her marriage and rose to a fury, raging against her unloved lover because he did not seem ready to keep his promise.)

Halfway oriented by the patient's initial account, the therapist endeavors to fill in missing links and obvious gaps. The direction of inquiry is prescribed by the clues received and by the probabilities indicated in the patient's description and behavior. There are many questions a therapist might ask to fill those gaps: When were they first aware of the symptom? At what particular point? What happened then? What before? Was it repeated? In what circumstances? Had they ever before been aware of this possibility? For themselves? In others? Who were these others? Who were they to the patient? Not all these questions are applicable in every case. The idea is that material offered initially is reviewed, supplemented, and possibly corrected upon

direct questioning.

For instance: Patient D. complained about impotence. The man is married and the relationship is quite a good one.

"What kind of impotence? Can't get it up? Can't get it in? Can't maintain it erect? Come too quickly?"

"No, no, sometimes it does not get hard. You know how marriages are."

"Quarrels? Is she demanding? Domineering? Sarcastic? If things have gone wrong, does she rub it in, complain, make fun of you?"

After several such questions and restrained replies, Mr. D. is asked whether he has ever had extramarital relations. After some hemming and hawing and asking back, the answer is affirmative. Had he difficulties in such an adventure?

"Yes. As a matter of fact, only in such relations."

"Always?"

"No."

"Often?"

"Well, I didn't have other women often."

"But when you had them?"

"Sometimes."

"But never with your wife?"

"Well, sometimes I am not in the mood. And sometimes she is not."

"On the average, how often have you intercourse with your wife? One time a week?"

"Two times, she doesn't want it more often."

"What do you do then?"

He hesitates and shrugs. "I think of other women."

"The girlfriend?"

"Well, her or others."

"Can you tell me her first name?"

"She is married. Her husband is lousy in bed, she says. I see her from time to time."

"And?"

"All right. But not so great. I am not in love with her. That's probably why."

"Possibly. And are you in love with someone else?"

He hesitates, then smiles and nods. "I guess I am."

"Give her a name, it needn't be her real one."

"Helena."

"And there you don't function?"

"I'm afraid so."

"And you believe that she loves you?"

"I know it."

"Is she also married?"

Resigned, nods.

"Are you afraid of the husband?"

"Oh no. He's nobody, a creep. She has nothing with him anymore. She is very pretty, attractive. A woman, sensual. Not at all like her sister."

"Who is her sister?"

"Well . . . well . . . she is the younger sister of my wife."

"But it didn't work out between you?"

"That's what I'm afraid of."

"You mean, you never were together with her?"

"Oh, we were together, but never alone. Never in . . . in . . . in bed, I mean. And it must not be as with Theresa. With Theresa it doesn't matter if I can't. But with her I must not fail. She would then treat me as she treats her husband. A creep. This time I must not fail."

"When is this time?"

"Tomorrow. Tomorrow we have our first date."

So there was the real crisis. D. turned out to be a weak man, maternally dominated by his wife, and his rebellious aggressiveness did not match his feelings of guilt and inadequacy. His apparently moderate sexuality, stirred up by an attractive woman who showed affection for him, challenged his not very impressive self-image as a man.

We solved his problem, what he saw as such, in the same session, and he enjoyed great success with Helena. However, at her urging he later returned for therapy to cement the fundamental personality structure.

In contrast to this simple case, in which little information was forthcoming and, in fact, required, considerably more information must be obtained in others. This is especially true if anxieties of long standing can be spotted. One may have to know about previous illnesses, therapies, upbringing, attitudes of and relations within the family, sexual and nonsexual relations with peers, hopes, fears, fantasies, traumatic and joyful happenings, preferred and hated activities, and, naturally, everything that has relation to sex.

Of course, it is by no means always possible to find all that out in one session, but then, exploration never ceases during the period of therapy nor do discussion and mutual instruction in either the hypnotic or the waking state.

With the benefit of this information, therapists usually have a fairly firm impression as to whether the case presented is within their com-

petence and, if so, how to approach the problem.

What they do not always know is whether the way they must lead the patient coincides with the latter's idea of treatment. If it does, therapists do not know whether clients who have not expressedly asked for hypnotic treatment are ready to submit to hypnotherapy and, if clients do agree, whether they are hypnotizable to the depth that their affliction seems to require.

Therapists must judge their own competence. Understandably, we tend to prefer methods in which we have training and experience and with which we have experienced good results. However, if our methods include only a few modalities, it is well to realize that not only do certain disorders yield more readily to certain of a variety of methods, but also different persons vary in their response to different approaches. In other words, a broad knowledge of hypnotic approaches prepares the therapist to handle a range of problems and to adjust the approach to the particular patient.

Hypnotherapy (Kline, 1955) is a general term that includes every method of hypnotism for healing purposes based on one or several common sense, psychiatric or psychological modalities, such as Behaviorism (Dengrove, 1976), Psychoanalysis (Wolberg, 1943; Freud, 1955; Schneck, 1951, 1962), specialized hypnotherapeutic techniques (Erickson, 1954, 1959), or any therapeutic doctrine. Hypnoanalysis combines hypnotism with principles developed by Freud, Breuer (1957), Sullivan, and Horney (1937). Abreactive therapy varies ideas developed by Breuer and Freud (1957), Hypnosynthesis rests on Adolf Meyer's modification of Dynamic therapy (Conn, 1968, 1960).

Every one of these schools rightly stresses some of its advantages, but every one also has some more or less serious limitations. Familiarity and experience with as many of them as possible, therefore, augments the therapist's knowledge and skill and enriches his armamentarium from which to choose the probably most appropriate combination of tools. Good judgment, imagination, and a sound eclecticism are the best guarantee for hypnotherapeutic competence.

Nobody is infallible. But certainly, knowing width and boundaries of the art make therapists more able than patients to decide whether the latter's expectations can be fulfilled and whether they are realistic or unrealistic and thus whether they should be treated as they fancy. Here is an example of this kind of problem. Mr. E. calls the doctor and says that he has been referred by a former patient. E. says that he wants the doctor to use hypnosis to cure his problem, which is the same as the other patient's, impotence.

Mr. E. was a teacher, twenty-eight years old, married, quite good

looking, healthy, and rather brash in his manners. He wanted to be cured of his impotence, but he was in a hurry. He had a job in Alaska waiting for him and was expected there in two weeks or so. But, he stated that he was a good hypnotic subject.

"That may help, but one really cannot predict."

"You fixed my friend in a short time."

"Every case is different. I need more details before I can even make a guess."

"Alright. The details are . . ."

E. has been married for less than a year to the most wonderful girl. He had never had any trouble with intercourse before or in the first ten months. They had enormously enjoyed their mutual desire for each other, usually five times a day. But all of a sudden . . . Shrug.

"You became impotent?"

"Right."

"No erection?"

"Uh some. But at best we can make it three times in twenty-four hours."

When he recovered from his surprise, the doctor told E. that he did not need therapy. Maybe they had just overdone it, and if they wouldn't force it, he would probably recover his vigor. "After such reckless exploitation," E. was warned, "emotional fatigue is not rare. In every relationship, desire gradually diminishes . . ."

"That's it," E. interrupts. "She says I have no desire for her anymore. I don't love her. But I do love her. I have desire for her. I get ready as always, but nothing happens."

The therapist tried to explain it as a natural happening and that three times a day is quite an enviable standard anyway.

E. is not convinced. "She won't accept that," he insists. "She thinks I am tired of her and I don't love her anymore."

There followed a long admonition that high frequency of coition is not the only proof of love, et cetera, et cetera.

He was disappointed and asked for his hypnosis. The therapist called his expectations unrealistic, warned against overcharging the capability of the body, and told him that setting a rigid standard of sexual performance smacks of machismo, as if he judged his entire male personality exclusively on his record in bed. What he probably needed was a reevaluation of his wants and privations for which he compensated by sexual prowess. This would take time.

So, he was told that his was not really a sex case and the doctor wouldn't take it.

Mr. E. was very much offended and he parted with a curse and gave

some vulgar sexual advice of his own.

A different type of decision had to be made in the following frequently occurring type of case.

Mrs. F. came with a question concerning her husband. They had married a few weeks ago. During their honeymoon the young husband had surprised her with a gift. As she opened the nicely wrapped box, she was dumbfounded. It contained three pairs of bloomers, the kind of panties our grandmothers or greatgrandmothers used to wear. The knee length undergarment was made of fine white linen that was split open in the back, but provided with a band on each end. These were supposed to be wound and tied together above the hips. The three garments were cut so that they left a wide gap that exposed the cleavage of the buttocks.

The husband had asked her to wear this oldfashioned piece of lingerie whenever she wanted to make him happy. When she told him that she did not understand, he explained that if it were worn by her without any other clothing over it, he would get enormously aroused, more than by anything else.

She was outraged and refused to put those "nasty things" on in spite of his pleadings that this would prove her love to him and would keep his love alive for ever.

Was the man sick? Was he insane? Could anything be done about it?

Certainly, something could be done about it. The concept of fetishism was expounded to her, from those forms that are rather usual and socially tolerated to those which are considered aberrations, including the extreme cases in which they control the individual's sex life. She was reassured that apart from the oddity of some of the predilections, there is generally speaking, nothing abnormal about these people and there is no reason to fear the presence or the evolvement of a mental disturbance. This case in particular did not seem likely to lead to any acts that conflicted with the law. The worst was that he might turn to a prostitute to satisfy his fetishistic appetite, which admittedly might be bad for the marital relationship.

Even so, she was advised, if he were willing to undergo therapy, he might be motivated to give up his peculiarity. On the other hand, if she wanted to, she could be helped to endure this unusual desire and even enjoy it, as many people enjoy costuming and disguising themselves for a role in a play.

Mrs. F. had made her appointment without her husband's knowledge. She was asked to tell him about the conversation and bring him along.

He was ready to comply with her wish, but he was very unhappy about it. The reasons for her demand were again laid before him, her feelings of hurt, of degradation, or apprehension. He understood without trying to defend himself. On the other hand, he reacted as if, by interfering with an idea that he had secretly cultivated for years, the back entrance to happiness was now forever locked to him. With this fantasy he had stimulated himself to orgasm, but never tried to make it real. He had hoped that by marrying this woman he loved he would make his fantasies come true. His eyes filled with tears as he chokingly assured his wife that he would not let their marriage be ruined by insisting on indulging the fulfillment of a whimsical wish-dream.

Eventually the therapist summarized the pro's and con's of an adjustment on either the man's or the woman's part. The ultimate choice, he emphasized, however must be left to the couple.

A few days later Mrs. F. called again. She had decided to attempt to make the adjustment and asked for the therapist's support in this undertaking.

In most cases, the decision to use hypnosis is already made by the very existence of a not easily acceptable inclination. If a man presents with the request to be weaned of a similar fetishistic feature or of compulsive exhibitionism, there simply is no way more promising than some method of hypnotherapy.

Knowledge of this fact has spread in recent years (Schneck, 1970) among potential patients as well as among professionals in the field of health. Many of the former request hypnotherapeutic treatment, especially after being frustrated by other kinds of doctoring and therapy. To other patients, however, it must be suggested, and this proposal often meets with doubts and objections. Some are frightened because they know about hypnotism only through the horror stories advanced by television shows and magazine fiction. A considerable portion still identify it with primitive healing in the tales of anthropologists; some cannot bear the idea of losing control of themselves or of unknowingly giving away secrets they harbor; some fear everlasting dependency on the operator or what may be done with them in their unconscious state; and some fear they will never again be aroused.

Questions along these lines are often asked. They should be answered honestly and in good humor. Better still, they should be anticipated, and hypnotism and its use for treatment should be briefly explained. Moreover, patients should be told what to expect, what to do and not do, and what they are likely to experience in this state: They are not going to fall asleep. They should not obstruct the begin-

ning of a trance state by testing whether they really have lost the power to open their eyes or sit up to start discussing the state they are in. (They should keep that for later.) They should not be amazed at hearing the therapist speak to them. (How could they respond if they did not hear suggestions?) What they think, feel, or have to say is very important, but they should hold it until dehypnotized. Little can be done for them unless they cooperate. Conversely, they should not try hard and on their own, to get into a trance state. This calls for the mobilization of the powers of the cerebrum and weakens the appeal to the older layers of the brain.

In part to introduce patients to the sensations of a trance and at the same time to measure their hypnotizability and determine the most promising hypnotic approach, they are given so-called waking suggestions (Appendix I). These are so administered that first the effect of imagination on body and parts of it are tested, then similar instructions are carried out against conscious and suggested resistance. Then brain functions are tested (counting, remembering, and forgetting of words) and ultimately more complicated exercises of unaware dictates of the brain on the nerves and musculature (hand and arm levitation, for instance). From the latter, patients are easily transferred into the hypnotic state. As they come out of it, they tend to be curious, intensely interested, and, most important, so delightedly relaxed that they often want to be put in the same state again.

Thus ends the initial interview. We do not often meet with people who are unhypnotizable. With the new "converts" the road is open to start actual therapy in the next session or to proceed with additional digging and exploration if such is necessary. Occasionally it happens that even a second session is superfluous as was the case with Mr. D. and others cited in this volume.

Once in a while, however, there are impediments to starting on the case directly. It may have been noticeable that patients withheld material or that they obviously lied, possibly because they made the appointment not voluntarily but under pressure. Or it may become evident to the doctor that the patients are not aware of the seriousness of their difficulties. In such circumstances, the obstacles to a successful treatment have to be cleared away before therapy can begin.

Chapter 2

PRETENSE, PREVARICATION, AND SELF-DECEPTION

OCCASIONALLY people are being sent for hypnotherapy who do not want to be hypnotized. The reason for the reluctance may be distrust of hypnotism, insecurity, fear to surrender control, or secrets pertaining or not pertaining to their disorder, which they do not want to be exposed. But, being pushed by the spouse, by parents, or an authoritative agency, they do not refuse the order lest they arouse suspicion. Rather they try to extricate themselves from the awkward situation by other means. They declare to the therapist that they are not hypnotizable, or that they fear to become forever dependent on the hypnotist. Some are courageous enough to submit, but hope that they can pretend to be hypnotized and falsify their testimony to escape the assumed dangers. And still others naively expect an examination so narrowly focussed on one specific issue that the other, the frightening one, will not be brought up.

Since hypnotherapy requires a certain amount of cooperation, disappointment of prevaricators is frequent. As regards the pretenders in particular, their secrets are fairly safe, but their silent denial of cooperation is not. The pretense is relatively easily discovered, but it would, of course, be unacceptable to intrude into the privacy of obviously nonconsenting adults, except if they finally conclude that they are better off to trust the operator's discretion than to be marked as pretenders.

Pretending to be in the state of trance, therefore, is rare. But attempts to withhold information possibly essential to the understanding and elimination of the sexual problem is not (Beigel, 1953). A heterosexually impotent man, for instance, may forget to mention his ongoing homosexual pursuits.

If such possibilities are suspected, one may hazard a guess to make sure. However, direct questions are not always rewarded with success. Questions under hypnosis fare somewhat better. But here, too, the therapist may be blocked. The patient may not be able to talk intellegibly, at least at first. This can be corrected by telling patients that they will have no difficulty talking. Simultaneously lightly stroking the skin over the larynx ordinarily helps. Of course, it does not if the

patient is consciously or unconsciously motivated to remain silent.

If patients do not respond, a technique may be applied that is not dependent on speech. Patients' hands are placed in easy sight and they are instructed to let their hands answer questions for them. The right hand will answer with yes or no to the best of his knowledge — yes by raising the index finger or no by raising the thumb. If the patients cannot clearly remember, if they do not have sufficient knowledge, or if the right hand cannot answer the question completely, for whatever reason, the left hand acts as control. Again, the index finger stands for yes and the thumb stands for no.

Theorists are not agreed on the explanation of this useful tool. Some ascribe the corrections of left hand signaling to the unconscious (Kroger, 1976). Others refuse to believe in such an agency (Weitzenhofer, 1960). But it is not necessary to interpret this debated phenomenon in Freudian (1955; Thompson, 1952) or any other terms. It is still a convenient expression for forces that reflect thinking, feelings, and behavior unbeknownst to the patient. In the specific case of finger signaling, the liar's mind is split into the knowledge of what is true and what he wants others to believe. In the relaxed state that unfailingly chaperones the trance, the cortical intentions apparently have quieted down to such unconcern that the would-be prevaricator is not quite able to suppress the revealing thought that pushes to the fore. As a result, the dissembler, avoiding the stress involved in artful instead of simple presentation, moves the finger selected for the easier, truthful reply.

Finger signaling is, however, not the only resort for eliciting undisclosed material. For example, with women who are unorgasmic, it is possible to suggest rather early in therapy a pleasant imagery: "There will now unroll in your mind's eye a very gratifying picture. You will relive the most exciting sexual experience that you ever had, either in reality or in your imagination."

Rather often they report sexual intimacies with other females. One young woman pressed her hands against a breast and whispered "Wonderful."

"What was so wonderful?"

"She kissed and sucked the nipple of my breast."

"A woman?" "Yea."

Another jumped up from the couch and ran into the bathroom. On her return, breathless, she sighed "Orgasm."

"What brought it on?"

"I had a dream. A beautiful woman kissed me deep in the vagina."

Both had never mentioned homosexual experiences, dreams or day-