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Clinical Hypnosis and Female Sexual Dysfunction: A Case Report

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Abstract

Background: Female sexual function comprises variable and multi-layered conditions that incorporate complex interactions of physiological, psychological, and interpersonal components. Despite the progress in understanding the neurobiology of sexual response, the definition of normal sexual response in women remains unresolved. Normal female sexual function differs from individual to individual and depends on the culture, ideology, beliefs, and other factors.

Methods: We used a case report, the purpose of which is to justify further investigation into the effectiveness of hypnosis for the treatment of cervical pain during penetration, as well as orgasm disorder.

Results: An orgasm was reached by masturbation performed on her by her partner, but without an orgasm by penile-vaginal penetration. The frequency of sexual intercourse has increased (3-4 times/week) in comparison to prior to therapy (once/ 2 months). Orgasm does not occur by self- and by partner masturbation every time, but sporadically; however, more frequently than before therapy. Success has been achieved with the orgasm by penile-vaginal penetration.

Conclusions: Hypnotherapy may be a promising co-intervention or intervention per se for both physical and psychological symptoms. The results of hypnotherapy demonstrate that symptoms were significantly alleviated and, consequently, the quality of life improved. Symptoms of pain during sexual intercourse were not eliminated, but the patient had achieved significant control over those symptoms.

Keywords: female sexual dysfunction, orgasm, sexual intercourse, pain

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1. Introduction

Female sexual function comprises variable and multilayered conditions that incorporate complex interactions of physiological, psychological, and interpersonal components. The roles and differences of female individuals, life experiences, and the socio-cultural influences of society are not negligible. Despite the progress in understanding the neurobiology of sexual response, the definition of normal sexual response in women remains unresolved. Normal female sexual function differs from individual to individual and depends on the culture, ideology, beliefs, and other factors.

Regarding sexual response, vaginal lubrication, arousal, contractions, and orgasm seem to be completely universal and reflexive in a sexually functional woman who receives appropriate sexual stimulation, but the subjective or emotional aspects are specific and are the result of experience and cultural factors[1].

Female sexual excitement encompasses a) mental state (emotional and cognitive) and b) physical state triggered by various stimuli, and can provoke feelings of pleasure and desire/need for further stimulation. Changes in the physical condition include an increase in heart rate, blood pressure, respiration, blood flow in the genitals, lubrication of the vagina, and congestion of the nipples. Physical arousal can be present without emotional/cognitive arousal, and vice versa: emotional/cognitive excitement can be present while physical arousal is absent[2,3].

It is necessary to emphasize that in the process of excitement other senses are also involved, such as vision, hearing, taste, smell, touch, and fantasies that can significantly contribute and/or participate in the creation, preservation, and enhancement of the arousal. However, it is necessary to emphasize both the physical as well as the emotional component of the human touch, since most of the mutual sexual acts contain exactly this feeling. The female body's erogenous zones are diverse, and appropriate stimulation and sexual excitement can trigger sexual arousal. These are the lips, back, neck, ears, forearm, breast and nipples[4], mons veneris, the inside of the thigh, buttocks, anus, and abdomen; the most sensitive structures are the genitals[5]. In these places, stimulation can be performed in the form of manual stimulation and/or stimulation using the tongue or implements, such as vibrator, dildo, and other mechanical instruments. Finally, in addition to the mentioned stimulations, it is necessary to emphasize that penile-vaginal penetration allows stimulation of the vaginal, clitoral and cervical part of the female genitals, while other stimulations enable the formation of unique feelings due to multifunctional stimulation. It is therefore expected that this way of sexual intercourse will lead to orgasm faster than stimulating only one part of the female body. However, some women report that stimulation of the clitoris stimulates them more quickly and gives them more intense orgasms, which are usually not as satisfying as those experienced by penis-vaginal sexual intercourse[6-9].

Several effects exist that increase or inhibit female sexual arousal, including disorders that discourage sexual activity. These are mutual problems, self-control, and for some also the awareness of the partner's physical excitement (if the woman feels obligated, this is usually negatively influenced). The stimuli generated by genital arousal do not always influence the subjective excitement of a woman[10]. Negative factors that influence the arousal are fear of sexually transmitted diseases, past negative sexual experiences and abuse, fear of conception, and low self-esteem[1].

A number of psychological factors, thereby blocking neurological signals that allow genital and other forms of somatic arousal. These factors include non-sexual disorders, a feeling of sexual anxiety, and a memory of bad experiences from the past. Insufficient arousal or absence of excitement can often occur in women who have experienced sexual abuse (the person is internally conflicted and consciously discourages sexual stimulation). Depression is one of the most common factors that obstruct sexual arousal. The limbic and paralimbic network that processes sexual stimulus data receives signals from the noradrenergic and serotonergic neurons of the Locus coeruleus and Nuclei raphe in the brainstem. Reduced synaptic concentrations of noradrenaline and serotonin are likely to contribute to depression and to the inability to appreciate sexual characters and triggers. This means that drugs that increase synaptic noradrenaline or dopamine increase sexual response while serotoninergic drugs reduce it. One of the biological factors that reduce sexual responsiveness is fatigue, for example, due to lack of sleep (insomnia, mood disorders, sleep apnoea, mothers' new-born baby), or health conditions that cause fatigue (renal failure, multiple sclerosis) and hormonal factors[11].

While in men only one type of orgasm is known, at least two types of orgasm are described in women. The first

type of orgasm is caused by direct stimulation of the external clitoris without any vaginal stimulation, called a clitorally activated orgasm (CAO). Another form of orgasm is described as the orgasm reached during vaginal penetration without direct stimulation of the external clitoris, vaginally activated orgasm (VAO)[8,12].

Sexual dysfunction can be lifelong or acquired, general or situational, psychogenic, or the incidence of it depends on various factors[13]. Sexual dysfunction involves problems that occur during the cycle of sexual response and prevent an individual from experiencing sexual satisfaction. It is relatively difficult to evaluate the prevalence of female sexual dysfunction because the definitions and diagnostic criteria remain in the development phase because the symptoms and signs are not as clear as in male sexual dysfunction. In addition, it is much more difficult for women to estimate specific problems, such as desire, arousal, moisture, and orgasm, as many factors affect them. Chen et al.[14] further state that the guiding issue in women is psychological or pathophysiological.

Women's sexual dysfunction includes libido disorders, arousal, lubrication, pain/discomfort and inhibition of orgasm. Although satisfaction with sexual life/relationship in diagnostic criteria is not present, it is one of the critical criteria for female sexual function[15]. Sexual dysfunction occurs over several phases and includes time sequences. Thus, problems affecting one area can also have a parallel effect on the other (usually in a complex way) and cause mutual overlap of diagnostic categories[16]. Normal and abnormal sexual function in women is still poorly understood since they are influenced not only by physical but also by psychosocial factors. In laboratory testing, problems with evaluation are encountered, which creates difficulty in diagnosing and treating female sexual dysfunction. There is still insufficient data on the effects and safety of the long-term treatment in the treatment of female sexual dysfunction with hormonal therapy[17].

Sexual dysfunction that is not caused by an organic disorder or illness comprises a group of behavioural symptoms associated with physical factors and physiological disorders. In this group, it is characteristic that a person is not able to participate in a sexual relationship or does not want to. Dysfunction is common but must be present for at least six months to confirm the diagnosis and cannot be attributed to other mental, behavioural or physical disorders or the treatment of drug addiction[18]. It is not negligible that various biological and psychological factors can have a negative impact on the female sexual response cycle, which can lead to the female sexual dysfunction[17].

Sexual dysfunction is defined as a group of problems that occur at any stage in the sexual response cycle, as well as pain during or after sexual intercourse[17]. Risk factors, aetiology and psychological aspects of the occurrence of sexual dysfunction in women (not caused by an organic disorder or disease) are classified into four categories:

- sexual desire disorder,
- unsuccessful sexual response (lubrication) or sexual arousal disorder,
- orgasm disorders,
- pain during or after sexual intercourse.

The review of literature also offers an increasing emphasis on the subjective satisfaction of women with their sex lives (when assessing female sexual disorders)[14,15,17,19,20].

2. Methodology

We used a case report. The purpose of this case report is to justify further investigation into the effectiveness of hypnosis for the treatment of cervical pain during penetration, as well as orgasm disorder.

2.1. Participant

Inclusion criteria were: (i) pain during and/or intercourse that is subjectively distressing and has been present for a minimum of 6 months; (ii) pain limited to intercourse and other activities involving vestibular pressure; (iii) a mean pain rating of at least 4 on a 0 (no pain at all) to 10 (worst pain ever) Likert scale and (iv) a moderate-high score (i.e. 6 or above) on the Harvard Group Scale of Hypnotic Susceptibility (HGSHS), and orgasm disorder. The female patient is 35 years old, in a 10-year heterosexual partnership, with a university degree, defloration at 17 years; sexual history: 10 sexual partners, one penile-vaginal orgasm (once, in 2008), self -masturbationno orgasm, by partner: very rare and/or no orgasm. Other categories: desire: no problem; arousal: no problem; lubrication: no problem (occasionally too much); orgasm: problem; satisfaction: occasionally problem/no problem; pain: frequently during penetration (cervix region; pain rating from 6 to 8); no history of (any) abuse.

2.2. Procedures and main outcome measures

The therapists were trained in medical/clinical hypnosis who received training sessions in both hypnosis and hypnotherapy and monthly supervision by a psychiatrist. The therapists conducted five therapeutic sessions.

The procedure was performed in a clinically controlled environment. The patient was scheduled for the HGSHS. The HGSHS reported medium hypnotizability. A complete gynaecologic examination reported no anatomic abnormalities.

2.2.1. Hypnosis sessions

1st session: the patient met with her therapist for a 1.5-hour assessment, followed by five weekly 45-minute hypnosis sessions. The first assessment consisted of the gathering of information about hypnosis, pain (situations in which pain was experienced), orgasm disorder and its consequences. In the first session, the patient was introduced to the hypnotic induction, deepening the hypnotic trans, and went to her own "safe place" or so called master control room technique'. The therapist used the Erickson induction of hypnotic trance.

2nd session: the patient had a 45-minute hypnotic session. After the hypnotic induction and the control of the depth of the hypnotic trance, the therapist used the regression method to determine the aetiology of the pain during penal-vaginal penetration in the cervical area. The second regression was performed to determine the aetiology of the lack/absence of the orgasm.

3rd session: the patient had a 45-minute hypnotic session. After the hypnotic induction and the control of the depth of the hypnotic trance, based on the finding the therapist provided exclusively tailored scenes for the hypnosis. The suggestions included personal relaxation, pain control and reduction in the cervical area, sexual pleasure, and an orgasm experience. It also included scenarios involving pleasant sexual situations with foreplay, vaginal penetration without pain and orgasm. The imaginary scenario consisted of pain-free and pleasurable penetration. The therapist asked the participant to reduce her pain by using the method of pain control (e.g., imagining reducing the pain as she reduces the volume of the sound on the radio). This part was repeated three times, and the patient reported experiencing 1 or 3 on ratings on the pain scale.

4th session: the patient had a 45-minute hypnotic session. After the hypnotic induction and the control of the depth of the hypnotic trance, based on the finding the therapist provided exclusively tailored scenes for lack/absence of the orgasm. Besides relaxation and sexual pleasure, it also included scenarios involving the patient to be present in her organ or organ system where the cause of her problem is. The patient "finds herself" in the vagina. After that, the instructions were to fix the problem in relation to her discomfort, with the clear instruction that she perfectly knew how to fix it. The post-hypnotic suggestion was to intensify self-masturbation and masturbation performed on her by her partner. This scenario lasted for 10 min.

5th session: the patient met for 45-minute hypnotic session. After the hypnotic induction and the control of the depth of the hypnotic trance, the therapist used the method of reinforced suggestions and the method of strengthening the ego. The patient received the post-hypnotic suggestion that sexual intercourse is painless, and sexually pleasant.

Follow-up sessions: Follow-up sessions took place one week after the 5th session and 6 months after the end of therapy. The patient underwent the same procedures post-treatment as she did pre-treatment: interview, questionnaires, and pain threshold measurement; the gynaecological examination was not repeated based on the first examination showing no anatomic abnormalities. The questions were regarding their satisfaction related to the hypnosis treatment (0 = completely dissatisfied, 10 = completely satisfied) and perceived improvement (1 = no improvement, 2 = little improvement, 3 = average improvement, 4 = great improvement, 5 = completely cured).

3. Results

In relation to the satisfaction with the hypnotic treatment, the patient gave a rating of 10. The first follow-up session was performed one week after the 5th session. Three days after the 5th session, she experienced an orgasm by masturbation performed by her partner but did not have an orgasm by penile-vaginal penetration. With penile-vaginal penetration, the pain was evaluated on the scale as 3.

The next follow-up session was performed six months after the 5th session. The frequency of sexual intercourse

has increased (3-4 times/week) in comparison to before the therapy (1 time/ 2 months). An orgasm does not occur by self- and by partner masturbation every time, but sporadically (before the therapy, orgasms did not occur, except on one occasion: see above). Success has been achieved with penile-vaginal penetration orgasm. The orgasm was present sporadically; prior to the therapy, the orgasm was not present at all. The follow-up in relation to the pain was between 3 and 6.

4. Discussion

The case report indicates that women with orgasmic disorder, pain related to intercourse, and noncoital vulvar pain benefited from hypnosis in terms of increase in the frequency of sexual intercourse, the experience of orgasm, and an increase in sexual functioning. The results prove satisfaction with the treatment and outcome. Authors suggest that hypnosis merits further investigation as an adjunct or primary therapeutic option. One author discusses that hypnosis has enormous contributions for the alteration of pain-efferent neural pathways[21-23]. Hypnosis influenced both the affective and sensory dimensions of pain and experience of orgasm and indicate that hypnosis may result from more than simply a combination of relaxation and placebo; it seems to involve the inhibition of neural signals[23-28].

5. Conclusions and recommendations

We suggest that hypnotherapy may be a promising co-intervention or intervention *per se* for both physical and psychological symptoms. The results of hypnotherapy demonstrate that symptoms were significantly alleviated, and consequently, the quality of life improved. Symptoms of pain during sexual intercourse were not completely eliminated, but the patient had achieved significant control over those symptoms. Further investigation would be needed to determine similar results in patients with a lower range of hypnotizability. The results are encouraging; however, the limited generalizability of a single case study should be considered.

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KLINIČKA HIPNOZA I ŽENSKA SEKSUALNA DISFUNKCIJA: PRIKAZ SLUČAJA

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Sažetak

Seksualna funkcija kod žena obuhvaća promjenjiva i raznolika stanja koja uključuju kompleksne interakcije fizioloških, psiholoških i interpersonalnih komponenti. Unatoč napretku u razumijevanju neurobiologije seksualne reakcije, definicija normalne seksualne reakcije kod žena ostaje nerazjašnjena. Normalna seksualna funkcija kod žena razlikuje se od osobe do osobe i ovisi o kulturi, ideologiji, uvjerenjima i drugim čimbenicima.

Metode: Primijenili smo prikaz slučaja čija je svrha opravdati daljnje istraživanje o učinkovitosti hipnoze u liječenju cervikalne boli tijekom penetracije, kao i poremećaja orgazma.

Rezultati: Orgazam je postignut tijekom stimulacije partnera, ali nije postignut tijekom penetracije. Učestalost spolnog odnosa povećana je (tri do četiri puta tjedno) u usporedbi s periodom prije terapije (jedanput u dva mjeseca). Orgazam nije postignut svaki put za vrijeme masturbacije ili stimulacije partnera, već povremeno, međutim, češće nego prije terapije. Uspjeh je postignut u postizanju orgazma tijekom penetracije.

Zaključak: Hipnoterapija može biti obećavajuća dodatna ili samostalna intervencija u liječenju i fizičkih i psiholoških simptoma. Rezultati hipnoterapije pokazuju da su simptomi znatno ublaženi, a time je poboljšana i kvaliteta života. Simptomi boli tijekom spolnog odnosa nisu uklonjeni, ali je pacijentica postigla znatnu kontrolu nad tim simptomima.

Ključne riječi: seksualna disfunkcija kod žena, orgazam, seksualni odnos, bol