Hypnotherapy for Pain Management, Self Esteem, and Re-establishing Sexuality & Intimacy after Surgery. Part 1: Case Presentation

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Abstract:

The effects of various types of surgery can disfigure the body, effect sexual functioning and intimate relationships, and consequently self esteem. Pain management, as part of a rehabilitation program, can also be an issue. This article is the first in a series of articles pertaining to the use of hypnosis for the treatment of pain management, improving self-esteem, and re-establishing sexuality and intimacy after cancer surgery. This first article will present a case study demonstrating how the use of hypnotic interventions combined with counseling strategies assist with pain management and improve self-esteem in a 55-year-old male. It will discuss options and information that is relevant to surgery that affects sexual functioning, and consequently self esteem and intimacy. It will discuss psycho educational strategies for clinical consideration, including how to empower the clients with information that broadens their knowledge of sexual functioning.

Keywords: pain management, hypnosis, self-esteem, sexual intimacy, surgery, cancer

Introduction

Cancer affects one in three people in Australia. An initial diagnosis of cancer can be challenging, frightening, and initially overwhelming for a patient. Information that can assist a person coping with that diagnosis is generally available from physicians, cancer clinics, and on the internet. A patient's ability to cope and adjust throughout the various stages of diagnosis, treatment and recovery is dependent on many personal and individual factors that include their physical, social, and psychological wellbeing (American Cancer Society, 2014).

Cancer surgery and treatment is painful. Types of pain felt after cancer treatment include:

- Pain or numbness in the hands and feet due to injured nerves. Chemotherapy or surgery can damage nerves, which can cause severe pain

- Painful scars from surgery.
- Pain in a missing limb or breast. - This is sometimes called phantom pain. (National Cancer Institute, 2014)

Hypnosis is known to be an effective tool for the treatment of both acute and chronic pain. Jensen (2008) indicates that hypnosis consistently produces significant decreases in pain associated with a variety of chronic-pain problems. Jensen (2008) review of the expanding knowledge of the neurophysiological basis of pain, suggests important implications for understanding how expanding the types of hypnotic suggestions, can be applied for pain management. The research demonstrates that including various types of suggestions covering the function of the various neuro-physiological pain processing sites that, in conjunction with hypnotic analgesia, can significantly increase the efficacy of treatment for pain sufferers. Other research as indicated that hypnosis can assist with sexual arousal and have global health benefits (Kirsch, 2001). Thus, hypnosis would appear to be the ideal treatment too for patient post-surgery.

Surgical treatment for cancer can lead to distress for patients on multiple levels, including body image, mood disturbances, sexual functioning, and self esteem.

Body image distress. Radical mastectomies, colorectal and pelvic exenteration, are not only painful, but can change the physical appearance and can cause significant disfigurement to the patients body. Whereas, surgeries that change the functioning of the body, such as formation of stoma's in the abdomen and removal of the anus, require adjustment, they can also cause considerable distress. Findings suggest that body image distress for patients undergoing reconstructive surgery is identified and treatment provided at the earliest possible time point. (Fingeret et al., 2014)

Mood disturbances. Depression is a co-morbid disabling syndrome that affects approximately 15% to 25% of cancer patients.(National Cancer Institute, 2014), and depressive symptoms in a minority of men with colorectal cancer were also associated with stigma, perceived blame and self blame (Pelhan, et al., 2013).

Sexual functioning. Cancer surgery is also associated with changes to sexual function and sexual dysfunction. Where genitals have been removed or affected by nerve supply, climax may no longer be possible. Other symptoms of sexual dysfunction can include loss of libido, impotency, diminished lubrication, and inability to ejaculate. According to Hendren, et al., (2005), "sexual problems after surgery for rectal cancer are common, multifactorial,

inadequately discussed and untreated" (p212). Taken together, these finding indicate the importance of screening and treatment for body image distress, mood and sexual disturbances, and early intervention for this vulnerable group of patients. Thus, effective treatments, are needed to help this vulnerable patient population.

Changes to sexual functioning after cancer surgery, can be overwhelming for the patient. After having endured treatments that may include body disfiguration, ongoing pain, that effects to their sexual functioning, the culmination is often overwhelming. Surgeons are often not equipped to handle these issues. Instead, they seem to prefer to focus and encourage the patient to draw comfort on the fact that they have survived. The impacts of body disfiguration and ongoing pain is far reaching, effecting the patient's sexual identity, and self esteem. They are often at a loss as to, or what, can replace their previous sexual experience. The challenge then, is the psychological impacts to a patient's changed physical expression of their sexual identity. In these cases, these patient may no longer have a frame of reference for their sexual identify. Thus cancer surgery can negatively impact a patients perceived self esteem, as they struggle to handle issues in relation to sexual functioning. The patient no longer has a frame of reference for their perceived value or worth in regard to their individual, and shared sexual identity.

Self Esteem. Evidence indicates that self esteem is subjective, and relates to an individual's belief as to their value as a human being. Good or high self esteem is not necessarily indicative of a happy person. Many destructive and malicious people would describe themselves as having good self esteem. Individuals may, if they are high achievers, feel good about themselves, and what they have accomplished. This can lead to individuals feeling confident, assertive, and entitled, but disconnected and miserable. Rather, healthy self esteem, involves a clearer awareness and respect for self and others. Clients with low self esteem do not necessarily see their value or contribution as of any worth. If using hypnosis, the clinician's role then, involves assisting clients to raise their self esteem whilst they develop, utilize and notice their skills in everyday living, strengthening. The client is effectively redefining their value, contribution, and worth as a human being. Yapko (2003), Baumeister et al. (2003).

The following Case study demonstrates how hynosis can be applied to help clients improve sexual functioning and re-establish intimacy, after cancer surgery.

Background – Presenting Case Issues:

[Name and age of participant has been changed]

Malcolm James* - Male 55 years old

In August 2008, Malcolm was diagnosed with a low rectal cancer that necessitated the removal of the lower colon. Malcolm had pre-operative chemo-radiation before he underwent surgery in Adelaide, in December 2008, followed by chemotherapy after Abdominoperineal Resection of Rectum (APR) surgery Australian Cancer Network Colorectal Cancer Guidelines Revision Committee (2005). As the cancer was very low in the rectum, there was not enough surrounding tissue to reconnect the colon to the anus, the APR resulted in the formation of a permanent colostomy. The surgeon had advised Malcolm that the surgery may result in inability to have an erection, as some nerves may be severed. In Malcolm's case this did not occur and he was able to continue with normal sexual activities and functionality. The results of treatment were good, and overall, Malcolm made a speedy recovery. Regular blood tests for the following four years were good, with nil evidence of recurrence.

In early 2012, blood tests indicated elevated CEA levels (tumour markers). Follow up scans and MRI's revealed a pelvic recurrence - a large tumour in the pelvic floor – with the prognosis of a very short lifespan (6-9months) without surgery. The local recurrence of rectal cancer; a disease which is confined to the pelvis, is often deemed inoperable and incurable with palliative care management as the guideline Australian Cancer Network Colorectal Cancer Guidelines Revision Committee, (2005). Malcolm was referred interstate, for assessment and suitability for resection with a multidisciplinary team, at one of two units in Australia that perform maximally invasive surgery known as Pelvic Exenteration. The aim of this surgery is to removal all the malignant tissues with a perimeter of surrounding normal tissues from the pelvis to achieve a clear resection margin and increase survival rates of up to 5 years. Malcolm underwent pelvic exenteration, which included the removal of the pelvic floor, prostate, bladder, and surrounding tissue, and significant plastic surgery reconstruction of the pelvis to fill the area removed, to aid healing. Three separate surgical teams performed this complex, and long surgery. The surgeons advised Malcolm that after the surgery, he would be unable to experience erection, but that options such as implants etc could be explored. However, the surgeons also advised that orgasm would not be possible.

Malcolm already had a colostomy bag, from his first operation, and now he also had a 2nd stoma and bag for urine collection. In Malcolm's

case, it was not until he was on the operating table that the full extent of the malignancy was evident. It was adhered to his left lower sacrum and hip, and had to be chiselled off the bones. While the final pathology report showed clear margins for removal of the malignancy, ultimately, the cancer metastasized to his lungs, reappeared in the pelvis, causing a blockage in his small intestines, and in the original bone sites.

Malcolm survived for 53 weeks, after his 2012 surgery. Although he was a positive, cheerful, motivated and driven personality, and believed he would fully recover, his final year was difficult, with significant pain and debilitation due to the surgery and the many challenges it presented – with pain, overall weakness, and immobility causing him frustration. His personality changed due to sleep deprivation, anaemia, and mental fatigue. Continuous changes to his pain medications were necessary, with little permanent pain relief for him from the various medications prescribed.

He initially wholeheartedly trusted the medical model only, but after some months, was willing to try anything to address the pain. Ultimately, it was not until he had injections into his spine/lower back at the Pain Management Centre that his back and leg pain levels stabilised, but by that stage he was beginning to experience the fatigue that was part of his latest diagnosis of Stage 4 Metastasized Lung Cancer (terminal). The back/lower pain he endured was probably the cancer as it re-established in the bones, and the new growth was also invading into the spinal nerves.

Therapeutic Support & Outcomes using Counselling & Hypnotherapy

Malcolm's initial request (to the author) was for counselling support. He knew the long term affects of the illness and surgery were affecting his personality. He reported that he was "constantly irritable", "difficult" [to communicate with], and he said he "could not see a way forward". His own body image was severely challenged. He had significant scarring and with two external abdominal bags; he viewed himself as a "freak". In particular, he felt that his "manhood was gone", and that he was "useless as a partner both physically, and intimately". Initial discussions were around elevating his self esteem, and options for pain management. Eventually, in frustration, he agreed to try hypnotherapy to see if it would assist with relaxation, stress reduction, and sleep deprivation. He was not interested in undergoing facilitated hypnosis; however, he agreed to listen to some hypnosis CD's.

I explained to him the process, what to expect, and that it was not necessary for him to listen, if he fell asleep. The initial CD I gave him to listen to was for relaxation and stress reduction. He began to listen to the CD *'Lifestyle*

Changes Fences and Boundaries', (Stewart, 2012) during the day. Within a few days, he noticed a subtle change, he seemed to be a little more relaxed, had slightly longer periods of pain free time, and was sleeping slightly longer.

There were discussions around sexuality and intimacy, including how the brain and its chemicals are responsible for stored memories that can activate desire and passion. It is the brain, not the genitals, that is responsible for the initial sexual response to stimuli, including sexual preferences, leading to sexual desire (Komisaruk et al., 2007). The brain and its chemical coding is the most significant influence on what is achievable in terms of intimacy and shared sexual experience. This includes the possibility of orgasm without erection or ejaculation (Komisaruk et al., 2007). Discussions were around what could also be achieved and shared intimately. Next, I then introduced a CD called *'Lights and Mirrors for Parts and Pieces Reintegration*' (Stewart, 2012). This CD seemed to facilitate a significant shift for him, in that he reported on awakening one morning, that he had experienced a sexual dream, and woke during it while experiencing an orgasm.

He was "pretty amazed" and excited about that experience. This opened up an opportunity to re-iterate the content of previous conversations - specifically, that he could (re) experience orgasm without erection or ejaculation. It was a turning point for him in terms of his understanding of what were the possibilities for himself and his partner. Ultimately, in intimate times, he found (sexual) excitement and enjoyment in bringing his partner to orgasm, and with some shared sensitivity and passion from both individuals, - they were both able to (re) experience orgasm again in each other's arms.

Significantly, what is interesting is the type of orgasm that was experienced. This type of orgasm is what is traditionally sought after as part of Tantric or Karezza practices (Muir, 1989; Bass, 2009). This type of orgasm is particularly strong, and felt as a whole body intense experience, as opposed to the more traditional, genital/abdominal area experienced orgasm. The process of orgasming for Malcolm was initially painful – and he described it as a "bitter/sweet" experience for himself. He also described it as a "difficult, but a nice (liberating) experience." This was due to the significant abdominal surgery that he had undergone, with the nerve pathways in his abdomen being highly sensitive and uncomfortable. Malcolm was interested in exploring how far he could go in regaining his functionality. On his final visit to the Pain Management Clinic, Malcolm asked for a prescription for Viagra to see if that would work. Unfortunately, he deteriorated very quickly around that time, and although he filled the prescription, he never died before testing it.

Crucial factors influencing Malcolm's achievement of orgasm without erection and without ejaculation was the open communication between Malcolm and his partner, including their shared personal commitment and support of each other.

Review and Observations

Hypnotherapy (and counselling) is well documented as providing good outcomes for pain management, assisting with self-esteem, and stress management (MayoClinic 2014). The extensive and significantly invasive nature of pelvic exenteration surgery, with its long healing and recovery times, raised significant issues around quality of life for Malcolm. While medical advice was readily available for such things as diet and medications, it became apparent that a significant gap existed in the area of advice available via counselling. For example, techniques to enhance emotional options for expression of sexuality and intimacy, where not addressed. Advice and referrals for functional options (i.e. penile implants etc. to facilitate erections) is available from his physicians. However, the deep and emotive effects to his self-esteem were shattering. There was minimal quality information available to Malcolm regarding his emotional expression of, what is arguably the most intimate of human interactions, intimacy through sex. Malcolm had previously experienced a deep and satisfying relationship in this area. However, after surgery, he was at a loss as to how to identify a way forward, and did not know how he could re-establish intimacy with his partner. He had told his partner that he would understand if she preferred to separate and pursue a new life, although she did not support this as a realistic option for her. The medical model focuses on normalising the alterations to physiology; however, it is limited in it's ability to offer new possibilities.

While Malcolm's surgery (pelvic exenteration) may present significant challenges for facilitating nerve regeneration (due to the extensive organ removal and the pelvic floor reconstruction/plastic surgery), for prostate or other less invasive colon/colorectal surgery, there are significant opportunities to explore in terms of nerve regeneration, and possible functional restoration. Converely, hypnosis has the capacity to suggest possibilities, and help a client shift their perspective.

Malcolm was initially sceptical of the ability to re-establish orgasm. Despite this, he was interested in techniques to facilitate the re-establishment for his partners benefit. Thus, techniques were explored and implemented, and Malcolm was pleasantly surprised when he experienced his own orgasim. Consequently, regardless of the severity and extent of radical surgery, at the very least, as demonstrated and achieved by Malcolm, restoration of the

experience of orgasm is achievable after any surgery. This was a significant contributor to elevating his self-esteem, but his most significant feedback was the personal joy he felt and being able to (re)experience and (re) implement an unexpected level of intimacy with his partner. For Malcolm, the combination of hypnotherapy, new information and self management tools were pivotal to him reaching a new understanding of himself.

Comments

While Malcolm's initial request was for options to address pain management, self-esteem, and sleep deprivation, significant personal unmet needs were identified in the area of personal intimacy. This area is not well catered for within the current medical model, and the resulting significant psychological issues (depression and self-esteem) may effect healing, particularly for this extensive and challenging operation. There is a need for additional information and options available for patients who undergo any type of surgery that affects sexual functioning, and consequently intimacy levels

By providing additional information and options for these patients, a key overall value is to create new understandings between couples, and a broadened sense of possibilities, that can lead to profound experiences of intimacy through shared and loving attention.

Conclusions

The use and integration of hypnotherapy, was the turning point, and the most significant positive contributor to strengthening Malcolm's self-confidence, stress reduction, and assisted with minimising his pain. The provision of information of new sexual techniques and information from neuroscience gave him a new perspective on possibilities. The counselling and hypnotherapy contributed to changing subconscious belief patterns, and was instrumental in him regaining and re-experiencing sexual orgasm and re-establishing (deeper) intimacy with his partner.

The second part in this series of articles, will discuss strategies for clinical consideration. These strategies will include strategies to enhance and restore intimacy between partners, addressing erectile dysfunction, and re-establishment of erection after prostate surgery. Also, it will discuss how healthy emotional expressions of intimacy can be validated with the latest in neuroscience. These strategies, when used together, can provide techniques and tools to teach and empower the client, enable them to control their emotional responses, build healthy self esteem and strengthen their confidence.

The final part in this series of articles, will initially provide a discussion on what is known about traditional sexual functioning. It will focus on strategies to enhance sexual intimacy for those individuals who are confronted with the effects of surgery/illness where functionality of the genitals are permanently impaired, reconstructed or removed. It will provide psycho-educational information of how orgasm is possible without genitals.

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