

# APPLICATION OF EMDR IN THE TREATMENT OF SEXUAL DISFUNCTIONALITY AFTER HISTERECTOMY - A CASE REPORT

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## INTRODUCTION

Hysterectomy remains the most common major gynecological surgical procedure. Postoperative sexual function is a concern of many women and their partners (Lonnée-Hoffmann & Pinas 2014). Arbanas (2017) stated that sexual problems are possible after various operative interventions with some of them being physical pain, increased sensitivity and hormonal problems. Psychological problems are more common and occur with most women after surgery, changed body appearance, fear of unattractiveness, and fear of their partner discarding them, fear of pain during sexual intercourse, and the similar.

The hysterectomy rate differs from country to country, but also within a particular country, depending on the morbidity, organization of the health system, tradition and attitudes. Aging Health (2013) states that every year in the United States there are about 600,000 of these operations so that every third woman at age 60 has hysterectomy. In Great Britain hysterectomy is done to every fifth woman. Catharina Forsgren and Daniel Altman (2017) from the Carolina Institute in Sweden warn of the long-term effects of hysterectomy on female health.

In our environment, Laćarak (2015) sees hysterectomy as one of the most common operations in gynecology. The same author states that only in the Gynecology and Obstetrics Clinic "Narodni front" in Belgrade last year 1,077 hysterectomies were performed out of a total of 5,184 women who underwent surgery.

For many women, the decision to remove the uterus is important and emotionally difficult. Psychotherapist Pamela Stephenson Connolly (2017) finds that dealing with major health problems affecting women's sexuality, the most difficult obstacle to their sexual healing is often the incapacity to allow themselves to bring back sexual pleasure to their lives.

It is quite normal that after facing such great pain and trauma, sex has a negative connotation and links it with the negative aspects of sexual physiology. The objective possibility from nerve intersection, completely new anatomical relationships in the abdomen, to associations in contact, can cause and trigger severe discomfort, traumatic experiences, etc.

Mitrović Jovanović (2017) finds that the same symptoms occur in women after hysterectomy as in menopause, but with a significantly different impact on the quality of life. Thus, Laćarak (2015) claims that the menopause symptoms, induced artificially are more severe than natural ones. Artificially induced menopause is accompanied by numerous complications. By extracting the ovaries that produce hormones, you introduce a woman into menopause with all symptoms such as hot flushes, mood swings, depression, and insomnia; sleep waking, claustrophobia, lack of concentration, bone and blood vessel changes. The same author states that it is different when nature gradually introduces a woman into the menopause. The female organism has time to adapt because the transitional period lasts more than 10 years, unlike the artificial one that occurs in a few days causing her early, sudden and unexpected sexual dysfunction. The magazine "ŽENA" under the title "My womb was removed and for three years we had no sex, because I no longer feel like a woman" contains the confessions of women after hysterectomy. Unfortunately, most women do not dare to ask a doctor or talk to their partner. They simply live with their thoughts and fears.

Although the largest number of severe surgical interventions to women relate to hysterectomy, which is performed in general anesthesia, no gynecologic obstetrics clinic in the world has a skilled psychotherapist who would help them in the healing process, and no gynecologist/obstetrician knows how to use psychotherapy techniques to help women in the first moments after waking up. In addition to objective difficulties and problems, ignorance, lack of information, uncertainty, and fear often result in unreasonable sexual dysfunction of women after hysterectomy. Unfortunately, in the literature there is not enough data on this issue.

However, Blažević (2011) includes EMDR as one of the methods for which there is the highest number of studies in terms of efficiency in different groups of people, and many consider it one of the most effective methods for treating posttraumatic difficulties and disorders. In the "application of relevant psychotherapeutic methods in the de-traumatization of migrants," Peterschik (2015) states that EMDR "worked out and developed as a valuable and effective therapeutic

method" and also how clients respond well to EMDR, and as a short-term form of therapy works very quickly (Hasanović 2014). On the other hand, this can also be an intensive therapy.

In that direction, WHO (2013), the International Society for Traumatic Stress Research, cites EMDR as a highly effective PTSD treatment, referring to the US Department of Defense / Department of Veteran Affairs Practice Guidelines considering EMDR as the highest efficiency category, as well as the American Psychiatric Practice Guideline. In the same year (2013), the World Health Organization recommended EMDR as an advanced therapeutic method for working with children, adolescents and adults.

Candy and others (2016) analyze 11 published studies that examined the "treatment of female disorders of sexual function resulting from cancer therapy" without clear results and no clear conclusions. From the studies that evaluated psychological support therapies, four studies have improved, and five did not improve sexual function in any of the measures used.

Unfortunately, in literature there are no results of psychotherapeutic studies of sexual dysfunction of women after hysterectomy.

## CASE REPORT

B.K. grew up in a multi-member, traditional, rural family in her own home. She had strict parents. She was particularly afraid of her father and his threats "if anything happened, God forbid" thinking of the possible shame that a girl can bring to him. She points out a number of temptations she had: parties, a lot of guys who were pushing, they had cars, she was young, beautiful... however, her fathers "NO" was inviolable, you had to listen. Although her parents died, she is still scared of them today. When asked "what is she afraid of?" The answer is: "My whole life I was suffering, I had restrictions, fears, I was poor, I had to watch out for everything, I was constantly told to look out for myself and be safe..."

After that, everything happened in three days. She had a regular gynecological check-up, which had the doctors' diligent question "Who did you come here with?"

After that, she went to Tuzla, had the surgery and then she started to feel like "her womb was gone"...

The client lists good socioeconomic condition of her parents, and her husband's was even better. They worked in a company, they did not earn a lot, but they lived well because they always saved money and worked in their own household, cultivating the land they inherited from their parents.

B.K. states a good relationship with her husband, well-tuned, harmonious, and almost idyllic. They did not have problems they couldn't solve, they had two kids. She did not use any contraceptive means which is difficult from a psychological side and which could be a

trigger in a situation where there is no uterus. That is, the disappearance of the uterus because of a decades-old cause of fear of conception may be a trigger now when it no longer exists.

## Current problem

General dysfunction, broken family relationships, guilt, fears for the future, sickness, fear of losing work. Scared at the entrance to the Mental Health Centre, she asks, "How far did I come" she worries, doesn't sleep, wakes up at night, overthinks. She has almost no sexual intercourses, and when she has them she is afraid and does not enjoy them, thus, she cannot relax.

## Case conceptualization

A quick and timely, medically justifiable surgical intervention ends with hysterectomy for women of mature age which are already weakened by menopause. Lonely, with no adequate psychotherapy support, shows symptoms of depression with suicidal tendencies and sexual dysfunction. By going on sick leave she stops being capable for work, and being frightened and insecure in everyday household activities, make her generally incompetent.

After establishing a therapeutic and supportive relationship, the client accepts a treatment plan that includes a standard EMDR protocol (Shapiro 2001) in combination with Elements of Integrative Gestalt Socioterapy (support circles, role playing, psychodrama (Moreno 1946), psycho education) once a week.

The plan consists of situation stabilization, processing traumatic events, informing and educating with elements of processing, establishing and nurturing a social network, accepting objective loss, awareness and the importance of other roles that she has as a human being.

## Treatment overview through sessions

### Session 1

In the preparatory phase of treatment, the fear and mistrust of the client dominated, which required the establishment of a stronger trust, and the installation of a safe place was followed. During the procedure where her history was taken, the client's suffering was dominated by squalid and suicidal behavior based on threats from her father (to keep an eye out, not to embarrass him), life's suffering to achieve an enviable status with two workers' salaries, prejudice towards a psychiatric institution, to general disappointment and life nonsense, inefficiency.

Although the client stressed the fear of death, acuteness, speed, and the suddenness of losing her symbol of femininity, for a target she chooses the most disturbing picture of an unsatisfied husband. She sees him as unusually angry, not careful as before and very quickly and often screams / shouts.

Negative Cognition (NC) was "I'm Insecure", while Positive Cognition (PC) was "I'm safe", the VoC (Validity of Cognition) was very weak, two, with fear. SUDs (Subjective Unit of Distress) is a five with a body sensation of the emptiness of the abdomen.

After agreeing to the "STOP" sign, the reprocessing and desensitization of bilateral stimulation (BLS) with eye movements followed. During reprocessing after each set of BLS client has got a series of images and accompanying sensations appearing:

- Fear followed by anxiety;
- The husband bread at the door, this set is accompanied by heavy breathing of the client;
- Lunch cooking goes bad and she transfers it from large to small dishes to get it to the dining room without hurting herself, in this set she cries;
- She carries garbage in small bags also being scared of hurting herself, she cries;
- Asks the husband to help her get her wet blanket from the washing machine;
- He screams, the client is silent and has a deep look;
- See his parents;
- Picture of the best friend who has cancer.

After another set of BLS, an unusually rapid change in the expression of the face occurred in a cautious, confident and categorical manner: "It's OK...", she kept silent and continued: "The problem is with me" after the new BLS set, the patient says: "I'm great "; after the next BLS she declares: "Picture of a friend"; "I'm awesome"; "I am successful". After a short silence, she continued: "I worked all day and it wasn't enough? ...no, it's up to me ... now I really feel good." Another BLS set is made, to the question: "What do you notice?", she said "I see myself".

VoC reported with 7, SUD - 0. After connecting a picture of an unsatisfied husband with new estimates, the same PK remains "I am sure", adds "and safe, and successful, and capable." VoC again is 7. After that, the body scan was done with the exercise "The Slap of Light". The client closes her eyes, concentrates on her body and imagines that a beam of light falls on her and illuminates the part after part ... after which she has not reported any remainings. She was suggested to remember the given image and the feeling.

After that, a closing of the session followed, instructions that the process will continue, she was told to keep writing diary, record dreams, and if needed to call them.

### **Session 2**

The second session began with the recitation of the last session and reporting the client about a more positive insight into their own. Dreams were like the thoughts of the previous seven days, interrupted, fragmented, and vague. She directed her interest and story to the desire to "have a good time with her husband like before," but to be worried for her health. Fear was the theme of the second session, and the PK

was that she is still worth it, that the feeling of comfort comes back to her. After BLS of the eyes, she reported low-intensity fears from the first session. The picture of a best friend who had a more severe form of cancer and had difficulty in chemotherapy returned to her. After her mother's picture appeared, her face again showed a change in the direction of determination and taking charge of herself. She reported several times: "I see myself as a good woman", then "I'm great looking".

After the VoC was 6, the question was what is necessary for it to be a 7, again she reported a piece of fear. She feels great but still cannot be relaxed with a husband. Fear concerned the possibility that "something does not break". Then I made a step forward and we talked about a way to relax, we dramatized, visualized one day, how she will welcome her husband, make him an unusual and his favourite dish, something that will remind them of their "good days".

### **Session 3**

The third session was dominated by mild positivity. She reported that things are improving since the last time, that she was clearing up, and that she had different and a little better understanding. During the BLS, she reported pictures of security; she did not shake when her husband was getting home from work. It's not easy for her but she does not panic if something is hard. It's not up to her, she did the best she can.

Several of her other roles also appeared, apart from the role of a sexual object: "I am a good mother, a good worker, except a maternity day, she didn't have a sick leave, a good friend, a good neighbor, a housewife," etc.

### **Session 4**

The client reports on the continuation of positive events. She established control over herself and household activities, she also received a few praises from her children, and her dearest compliment was her husband's. They had a relationship that for the first time was not suffering and discomfort for her. For this session she did not have the worst picture or event; she was persistent that this is the best one "cheerful picture of her husband" with the PC "I'm still worth it". To the question: "What does still mean to you?", she replied: "I can be useful". When asked where she can be useful, she says: "To my children, at work, I can hang out, live more..."

Most of the session she wanted to talk, she justified her husband's actions with his tiredness at work as well as his fears. She criticized medical staff who did not have time to inform her and explain to her the procedures and consequences. While she was in hospital, she was afraid and ashamed to ask what would happen to her as a woman after surgery?

After returning the positive images, the session was completed by installation, scanning of the body, closing the session and scheduling the control in 4 months.

### Session 5 - Control

After four months, the client called and asked for an appointment that she will come to with a series of positive changes, events and a different, positive view of the world. She is still on a sick leave and is looking forward to returning to work. She mastered her daily activities in the household; she receives the guests, but also visits them with pleasure. She has created quite acceptable sexual relations for herself, sometimes she feels the pain but with the smile she adds "sweet pain."

## DISCUSSION

This experience of applying the EMDR protocol undoubtedly confirms its' justification, efficiency and effectiveness in a very complex case. Its' application and efficiency in restoring the sexual function of a woman of mature age (58 years) after hysterectomy gives the right for even higher expectations for the effects of its' application especially for younger women.

The experience of this case points to the fact that the visibility, shape, form and weight of a woman's physical deficiency isn't of crucial importance for her reaction to the deficiency.. Loss of the uterus could be considered as nothing more significant compared to breast loss, for example. However, the lack of information and insufficient information about the procedure put the woman in a passive role and caused severe depression with the elements of anxiety and suicidality. Can you imagine pain and suffering that women go through after hysterectomy in fertile age, then the removal of ovaries, breasts?

Although the advancement of plastic surgery has greatly helped the physical appearance of a woman, there are no studies that show her feelings during irritation of the implant during the relationship and which could be a trigger of sexual dysfunction in this case.

In the case of the treatment of sexual dysfunction after hysterectomy, EMDR proved to be an ideal therapy focused on information processing with the aim of changing the burdensome internal memories that are activated in contact / stimulation with the husband. Eye-motion sets slowly, according to Peterschik (2015), have led to memory losing its strength and emotional charge. Any subsequent thought on the traumatic event became easier compared to the original and those before it. Eye-motion sets slowly made memories lose their strength and emotional charge.

To ease reckoning and thinking about the original event, desensitization has placed the shocking experience better in its past and made it functional experience, thus achieving the fundamental goal of EMDR that transforms dysfunctional stored experiences into adaptive resolution.

Explaining the above-mentioned process, Kovač (2013) assumes that trauma revival is associated with new, harmless experiences by reviving trauma with

disturbing stimulants. Solving the problem before important meetings and presentations for just one hour of EMDR treatment, Blažević (2011) explains that 'swinging' causes changes very often in a few seconds, the image fades and becomes one-dimensional. Many people after one or two sets of 'waving' can no longer remember the terrible images that are moving away and the person remembers 'from far away'. The voices, sounds and noise of the 'loud pictures' are silenced or completely tarnished.

The already mentioned case of the implementation of the EMDR protocol undoubtedly shows its ability to generalize the results. Restoring the sexual function of a woman stabilizes her integrity as being with all her roles. EMDR has rehabilitated the universal, general competence of a woman as a wife, mother, housewife, worker, etc. The transformation of dysfunctional stored experiences into adaptive EMDR helped the woman to think differently about herself in connection with traumatic memory.

The effectiveness of EMDR in PTSD treatment has been confirmed by the National Institute for Clinical Excellence as the best technique (NICE, 2005). Bisson et al. (2007) considers it the first choice for chronic PTSD in psychological treatment, while for Spates its et al. (2009) EMDR equally effective as a CTT targeted on the trauma.

The aggravating circumstances are certainly prejudices about everything that has a "psycho" connotation. The first interview began with astonishment in the form of "have I already come this far" (thinking about psychiatry), and who are you, what are you doing? ... Fortunately, the EMDR protocol in its vocabulary does not contain this flaw.

The effectiveness of applying the EMDR protocol to just one woman is also reflected in indirect help to the whole family from each sides, as a bright example to all other women who are in the same or similar situation.

Recognizing all the disadvantages of using the EMDR protocol in just one case, applying it and returning a woman to life can serve as a road map for a very large population.

## CONCLUSIONS

Hysterectomy for a woman is not just the removal of the ill organ, but a very complex psychologically emotional process that can result in mental disorder and suicide.

EMDR can help establish sexual function in women traumatized by hysterectomy, and her general competence and improvement of quality of life.

The therapeutic effect of EMDR restored the sexual function of a woman of mature age (58) and indirectly stabilized her whole being with all her roles.

EMDR can assist in resolving or alleviating the possible trauma to a large number of women who are exposed to surgical interventions.

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Fadil Imširović: conception and design of the manuscript and interpretation of data, literature searches and analyses, clinical evaluations, manuscript preparation and writing the paper;

Mevludin Hasanović: made substantial contributions to conception and design, participated in revising the article and gave final approval of the version to be submitted.

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