

CASE STUDY OF EMDR THERAPY USE IN TREATING REPRODUCTIVE TRAUMA - A CASE REPORT

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INTRODUCTION

The number of couples who struggle with infertility continues to grow every year. Bhat and Byatt (2016) believe that infertility and perinatal loss, collectively referred to as reproductive trauma, can change a woman's perception of herself and be a major source of stress that often has psychological consequences. Reproductive trauma occurs in up to 15% of women and is often associated with psychiatric symptoms or disorders (Bhat & Byatt 2016). The psychological impact of the infertility has been said to create distress equivalent to that associated with life-threatening illnesses and has been linked with posttraumatic stress disorder (PTSD) (Corley-Newman 2016). Not only can reproductive trauma lead to grief, depression, anxiety and post-traumatic stress disorder (PTSD), these psychiatric symptoms themselves have also been associated with infertility and miscarriage (Bhat & Byatt 2016). Healthcare in Bosnia and Herzegovina focuses on the medical side of these problems, and pays very little attention to the psychological aspects. EMDR (Eye Movement Desensitisation and Reprocessing) therapy is used for treating a great number of psychological problems and disorders. Unprocessed, maladaptively stored traumatic experiences cause symptoms, and EMDR therapy, in the safe therapeutic context, stimulates blocked processing of the memories of traumatic experiences and their adaptive storage. Clinical cases can illustrate the psychological consequences of reproductive trauma and the benefits of EMDR therapy.

The aim of the case study is a treatment history of a client who had multiple psychosomatic symptoms caused by traumatic experiences of ectopic pregnancies and IVF failures.

CASE REPORT

At the beginning of the treatment the Beck Depression Inventory and Beck Anxiety Inventory were applied, and symptoms were mild on both inventories. Subjective Units of Disturbance Scale (SUDS) was used during the treatment. The trauma timeline was applied and the most difficult experience of losing a foetus was

defined as the main target. The EMDR standard protocol of 8 phases was applied for past traumatic experiences, and also for trigger in the present.

The complete treatment consisted of 22 sessions and every session lasted 1 hour. The client (36 years) self-referred for therapy because of these symptoms: pain in different parts of the body, tingling, insomnia, headaches, stomach aches and shortness of breath. The comprehensive medical diagnostics found no medical causes of her state, so she self-referred for psychological help. The client got divorced 9 years ago, after only 6 months of marriage. She moved to another city after getting married again. She is employed in her field of interest. She had her first ectopic pregnancy 2.5 years ago, and then had another one after some time. She tried IVF procedures twice in Bosnia and Herzegovina, and attempted a third IVF procedure abroad. The third IVF procedure appeared successful until an examination in her 9th week of pregnancy found no heartbeat. Curettage without anaesthesia was conducted. After these experiences she had postponed a new IVF procedure.

The preparation phase consisted of 6 sessions. During the process of working on resources she mastered the implementation of the exercise «the internal safe place», the «Diagram of experiences of pride» was applied, and a «List for crises» was created. She chose to run as a hobby for relaxation. Negative beliefs that blocked her from seeing people closest to her as a resource were eliminated during the preparation phase, so she started to use her best friend, her sister and her mother as support. She felt much better after working on the resources, so she started to use the tablets IVF procedure preparation.

Some time was dedicated to treating fears associated with her husband's health, treating her anxiety associated with the unplanned pregnancy of a co-worker, and planning how to assert herself at work. Feeling old, and the gynaecologist's confirmation that she has old ovaries, gave her additional psychological pressure. The client pointed out war trauma, her divorce, her mother's illness (cancer) and her unsuccessful pregnancies as the worst experiences on her trauma timeline.

In the preparation phase the main target was defined as the moment when the gynaecologist told her there was no heartbeat at the medical examination in her 9th

week of pregnancy. She selected « I am not capable of being a mother» as a negative cognition. She selected «I am OK as I am» as positive cognition. Her «validity of positive cognition» was VOC=3. She selected sadness as a feeling and SUD=7 on the Subjective Units of Disturbance Scale. She placed sadness in the chest. Moving of fingers was used at the desensitisation phase. Sometimes tapping was used when she had abreactions. The blocked processing of sadness was assisted by helping the client visualise her sadness. She saw it as a ball in her chest.

During processing, she alternated between sadness, anxiety, anger and guilt. She was especially surprised by outbursts of crying and anger during the processing. During abreactions, dual awareness was kept by therapist vocalising supportive statements.

In the beginning of the treatment she responded with increasing pain, but as processing proceeded she responded with a smaller amount of all symptoms and they became less intense. The curettage procedure without anaesthesia emerged as a theme at the desensitisation phase. As the client stated, «I can't bury this», it became clear that she did not bid farewell to her dead child. Therefore it was suggested to her to bid farewell, because she had not had this opportunity. After she symbolically did this she reported that she felt better. After the desensitisation phase was completed her VOC was 6. «I am not completely OK if I have not become a parent» was defined as the blocking belief. After processing residual anger she gradually had positive insights, such as «It isn't my choice» and, «I do all that I can». After these insights, her VOC became 7, so the installation phase was conducted. The body scan was conducted and there were no other sensations in the body.

Four sessions were needed for treating triggers in the present. The client was triggered seeing pregnant women. The discussion about the negative cognition that goes with that event started with patient saying «I can't have what I want». when asked what that meant about her, she said «I am powerless». She formulated the positive cognition «I have a chance». Her VOC was 5. She felt a sense of sadness and rated SUD=7 on Subjective Units of Disturbance Scale. She located sadness in the chest. She stated powerlessness and anger during the desensitisation phase. She described an internal fight between the mind and emotions. The adoption of a child as an alternative emerged as an additional insight. The treatment also resulted in her considering the best options for IVF procedures abroad. Thinking about the future, she asked herself «What can I hope for?» and tried to imagine all possible scenarios to be better prepared.

It was possible to monitor her progress in processing indirectly from the themes of her dreams, which were scary at the beginning (theme of losing the child) but gradually became more positive (dreams with a child and a happy ending).

Upon completion of EMDR protocol all psychosomatic symptoms disappeared, but it also resulted in

changes on the cognitive and behavioural level. Negative blocking beliefs were eliminated during the treatment, and the client was ready to embark on further IVF procedures. She has even considered adoption, together with her husband, as an alternative.

DISCUSSION

While 9 to 15% of the childbearing population experience infertility, only about half seek infertility treatment (Bhat & Byatt 2016). An even smaller number of those ask for psychological support. Psychological interventions for infertility are important to promote both improved mental health and increased pregnancy rates. Infertile women who receive some form of psychosocial intervention are twice as likely to become pregnant as those who do not (Bhat & Byatt 2016).

Emotional responses to infertility include infertility-specific stress, as well as symptoms and disorders of anxiety and depression. Depression may reduce women's motivation to continue with fertility treatment after failed treatments. Common responses to infertility may involve loss of control, social isolation, low self-esteem and stigma. It is also interesting that despite successful infertility treatment, or treatment which results in successful pregnancy and childbirth, some women with a history of infertility experience higher levels of pregnancy-related anxiety, lower postnatal self-confidence, early parenting difficulties and increased risk of psychiatric disorders in the first 90 days postpartum (Bhat & Byatt 2016). According to this, effective psychotherapy may eliminate present symptoms but also may have a preventive role.

Shapiro (2002) states that EMDR therapy aims to include one event or events from the past which have caused problems, the present situation that causes distress, and key skills and behaviours which the client must learn to feel good in the future. In the preparation phase, improving social support for the client was an important goal. The social support can protect against depression and anxiety in the context of infertility. EMDR therapy has been effective for the client at eliminating symptoms caused by reproductive trauma. Not only did all the client's psychosomatic symptoms disappear, but she also experienced important changes at the cognitive level, which resulted in the client's better adaptation to her situation. Luber (2012) states that the most valuable result of EMDR therapy is achieved when the person is able to see things as they really are now, and not as a re-enactment of her/his past. This makes it possible for the client to assimilate new, positive life experiences and move in the direction of her/his goals.

The client got much more active in finding solutions, so she and her husband spent time finding the best clinic for infertility treatments. One further step was made when they considered adoption as an alternative for the first time and made contact with the Centre for Social Care.

CONCLUSION

Positive examples of EMDR treatment for clients with symptoms caused by traumatic experiences of infertility should encourage its further use with patients with this presentation.

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