ISSN: 2573-9506

Review Article

International Journal of Women's Health Care

Gynaecology and Sexuality Before and After Surgery. Some Operational Suggestions and Reflections

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Submitted: 2024, Jun 26; **Accepted**: 2024, Jul 25; **Published**: 2024, Jul 30

Citation: Righetti, P. L., Longo, S., Bonisoli, L., Battista, R. (2024). Gynaecology and Sexuality Before and After Surgery. Some Operational Suggestions and Reflections. *Int J Women's Health Care, 9*(2), 01-04.

Abstract

After several years working in a Maternal-Children's Department - therefore in a hospital reality including Obstetrics, Gynaecology and Pediatrics - and after having developed precise Operative Procedures, validated by much scientific research carried out in the field, we would like to bring to the reader's attention our experience with the intention of offering some operational and clinical suggestions and food for thought in the field of Female Sexual Dysfunctions that can occur after gynecological surgery (pelvic floor, uterine-vaginal prolapse, etc..) both in the case of laparotomic, laparoscopic and vaginal surgery. We start from the assumption that this article is not intended to be a treatise on Female Sexual Dysfunction, but simply a chance to get some simple and straightforward operational advice. Drawing on our own experience, on the following pages we give a brief introduction to Female Sexual Dysfunction, the concept of post-surgery Quality of Life, possible psychological intervention (before and after surgery) and what can be done from a psychological point of view from the "time" of hospitalization.

Keywords: Gynecological Surgery, Female Sexual Dysfunctions, Quality Of Life, Medical-Psychological Intervention

1. Introduction

1.1. For a Definition of Sexual Dysfunction

The Diagnostic and Statistical Manual of Mental Disorders DSM-5 assuming that Female Sexual Dysfunctions (as well as male sexual dysfunctions) can have a psychological etiopathogenesis, classifies them as "Female Orgasm Disorder [302.73 (F52.31)]", "Female Sexual Desire and Sexual Arousal Disorder [302.72 (F52.22)]" and "Genito-pelvic Pain and Penetration Disorder [302.76 (F52.6)]": are disorders that prevent a person from experiencing pleasure or having a gratifying and spontaneous sex life due to 1) pain during sexual intercourse, 2) involuntary painful contractions (spasms) of the muscles around the vagina, 3) lack of interest (desire) in sex, 4) problems with arousal or orgasm (i.e. not experiencing pleasure and not reaching orgasm) [1].

The psychological and relational aspect in Female Sexual Dysfunctions is always present: both as a cause - psycho-etiopathogenetic aspects (e.g: vaginismus on a psychogenic basis) - and as a consequence (e.g.: after surgery): in this sense, even if the cause is "post-surgical", a vicious circle can be established that activates psychological, sexual, relational, couple aspects. "During orgasm, the pelvic floor, particularly the more superficial musculature surrounding the orifices, contracts rhythmically. There is a correlation between the strength of the pelvic floor muscles and orgasm. Women who are an orgasmic compared to women who achieve orgasm have a significant deficit in pelvic

floor muscle strength. In fact, women with a weak pelvic floor who undergo rehabilitation achieve an improvement in sexual function.

Pelvic floor strength may therefore be one of many factors in the difficulty of experiencing pleasure during sexual intercourse or reaching orgasm, and this strength may be altered by surgery" [2]. In Gynaecology sexuality can be altered: by childbirth, surgery, infertility, adjuvant therapy, menopause [3-5]. In this article we focus on sexuality before and after surgery (vaginal and/or abdominal), considering it as one of the factors that can define a good Quality of Life.

1.2. Sexuality and Quality of Life

According to the WHO, Quality of Life (QoL) indicates the well-being of an individual, in his or her community, a person's perception of his or her own position in life, in the context of the culture and value systems in which he or she lives and in relation to his or her own goals, expectations, standards and concerns: physical, psychological, relational, social, belief and spiritual well-being. QoL is a subjective construct (it must be assessed by the individual), multidimensional, dynamic (it can vary over time and according to changing circumstances) and culture-related construct [6]. The main dimensions that define QoL are the physical dimension, the psychological dimension, the social dimension and the sexual dimension.

The sexual dimension often "drags" all the other dimensions. It is not possible to approach the treatment of sexual dysfunctions with a compartmentalized mentality without assessing the QoL of the person undergoing gynecological surgery; these problems have important psychological, relational and social implications, and limiting oneself to physical treatment alone may not be sufficient and therefore fail to respect the QoL.

In clinical work, one should always respect and refer to two (first) main rules:

- **Rule Number One:** listen to the patient, the couple, the signals and the pain without forgetting that it is the clinician who translates the "brought signal" into a "symptom".
- **Rule Number Two:** respect "time" because time often allows the recovery of sexual function, without - therefore - "pathologising" what is not pathological; time should be evaluated in the "now-for-next", in the meaning that pain can have now for later.

The main psychological and relational consequences for women in the post-operative period if the work on QoL is not taken care of may be [7].

- in work activity; increase in days of absence;
- in relationships; loosen relationships with friends and tend towards isolation;
- from the physical point of view: reduction in sporting activity;
- from the psychological point of view: appearance of anxiety, depression, reduction of interests in life, reduction of self-esteem and self-respect, frustrating feeling of no longer being the master of one's own body, appearance of a subjective feeling of ageing with the perception of having to depend on others;
- In the Family: loss of interest in housework, relationships with the partner and various family members become complicated.

Equally insufficient may be limiting oneself to treating a psychological or relational discomfort without considering and investigating the physical aspect.

Sexual function and response involve the mind (thoughts, emotions, psyche) and the body (including the nervous, circulatory, endocrine, vaginal, muscular systems). In fact, the sexual response includes [8].

- **The Motivation:** initiating or continuing sexual activity (desire for sex that can be elicited by thoughts, words, images, smells, tactile sensations)
- **The Stimulus:** composed of a subjective element (the felt and conscious sexual arousal) and a physical element (an increase in blood flow in the genital region). The increased blood flow causes swelling of the clitoris and the walls of the vagina (congestion), as well as an increase in vaginal secretions (which have a lubricating function). The flow of blood can increase without the woman being aware of it and without her feeling aroused;
- **The Orgasm:** the peak of sexual arousal. Immediately before orgasm, muscle tension increases throughout the body; with the onset of orgasm, the muscles around the vagina contract rhythmically. The orgasm can also repeat itself several times in a single intercourse;
- **The Resolution:** it is a widespread feeling of well-being and muscle relaxation, which usually follows the orgasm.

All this in a single plane of psychic/organic/relational meanings. If we evaluate the clinical and experimental literature, the resumption of a good post-surgical sex life (and thus a good QoL) may depend on: how prepared the woman (couple) is; counselling/support/information (from the doctor/psychologist); an objective/behavioral intervention on sex; specific psychological work on the couple; "not pathologising" the situation (if it is not pathological); improvement/recovery of the gynecological condition.

1.3. The Need for an Integrated Medical-Psychological Intervention

From what we have reported above, it is clear that our way of thinking about and clinically treating the patient undergoing gynecological surgery is always through a multifocal and multidisciplinary intervention: the center of interest (the focus) remains the patient around whom different specialists can move. In this sense, surgical intervention (gynecologist, urologist, other specialists), psychological therapies (psychologist-psychotherapist, sexologist, psychiatrist), the use of drugs (psycho-pharmacotherapy, hormone therapy, pain therapy), musculoskeletal, neurological, visceral, manipulative therapies (physiotherapist, osteopath), etc. "come into play", with the aim of coordinating several treatment possibilities and favoring an integrated Medical-Psychological intervention.

Very often the gynecological intervention is negatively experienced by the patient to the point of a modification/alteration (even psychopathological) of the Self Image, of the Body Scheme, of the Identity and of Being and Feeling like a woman; these are factors that determine and characterize the woman's Self, all the more so if we consider the Self in its relational exception where, therefore, there is also an alteration of the couple's relationship that brings into play the partner's "responsibility" [7- 9,10]. "We call the self the complex system of contacts necessary for adaptation in a difficult field" the self is an experiential and mediating event between the organism and the environment, we are not only ourselves, but also the phenomenon we are experiencing the self is relationship and working in sexual dysfunctions should lead us - as clinicians - to re-evaluate and redefine the spontaneity of relationship, sexuality and the fullness of the self both on an individual and couple level [11,12].

The multifocal mode of our approach also requires that: 1) there should be a good knowledge - for both partners - of the anatomy of the female sexual apparatus so as to find the best ways for arousal; 2) the couple should be self-aware so as to focus on what is happening in the here-and-now for the now-for-next without resorting to interpretations and thoughts that distort the arousal of the present moment as much in sexual intercourse (the subject of this article) as in the "healthy" couple relationship; 3) communication between the partners is improved; 4) the couple indulges in more types of sexual activity (caressing, touching and kissing the erogenous zones of the body can increase intimacy, reduce anxiety, foster trust, respect and emotional intimacy between the partners) [13,14].

1.4. Let Us Add Two (Second) Main Rules

- **Rule Number Three:** it is essential that the clinician "brings up" these issues even if the woman/couple does not and regardless of age.
- **Rule Number Four:** before and after surgery, it is essential to talk about the "downtime" of the sexual organs (which are muscles) and therefore the avoidance of sexual intercourse "for fear of not being ready".

The "taking care" is always relational both when it is addressed to the fusional (couple) and individual (her, him) aspects, and when it is expressed and done by a multi-professional team, and when psychotherapy or individual or couple sex therapy, or pharmacological therapy or surgical therapy is proposed: regardless of the theoretical model of reference, the psychological intervention should be in the here-and-now for the hereafter, in the now-for-next [15]. And when "caring" is addressed to a psychopathological state, it is necessary to work on the psychopathology of awareness of the patient, on the awareness of the situation that has arisen, in order to offer "tools of care" that cure the altered experience of sexuality [16].

1.5. The Hospital Management

Bearing in mind what we reported earlier about all the aspects that define the QoL and the emotional and psychological experiences of the woman undergoing gynecological surgery, the "psychological work" should start from the hospital period.

For several years at our Maternal-Children's Department we have been adopting Operating Protocols (validated over time with various experimental researches) which are divided into these main steps:

1. At Pre-hospitalization (day hospital) when the medical file is opened, the patient who is going to be operated on, in addition to carrying out instrumental examinations (blood test, ECG, CT scan, MRI, etc.), being examined by various specialist doctors (gynecologist, anesthetist, urologist, etc.), talking to the nursing staff, carries out a psychological interview that aims to work on awareness of what she is about to face.
Beyond what may emerge (fears, anxieties, difficulties, etc.) the psychological interview aims - always - to gather precise information and address these issues: age, marital status (family composition), psychological anamnesis, profession, precise knowledge of the medical diagnosis, knowledge of the type of surgery proposed, cognitive level, verbality, re-explaining the operating procedures and the behavior to be assumed at discharge, level of awareness towards what is explained to her, level of decision-making towards what is proposed, level of motivation for the surgery, psycho-clinical conclusions and the personological profile; this makes it possible to "prepare" the patient also for the post-intervention and to give extra information to the multi-professional team that follows her.
In these terms, the psychological interview also plays an important role for the signing of the various informed consents and for medico-legal protection. Right from pre-hospitalization, each psychological interview has its own transcription space in the patient's medical record and diary so that the whole team can be informed/updated (in paper format as well as in digital format).
2. To Hospitalization, on the day prior to the intervention, a psychological interview is repeated on the day of admission, which takes up what was discussed earlier with the aim of raising the patient's awareness.
3. During the Post-operative stay with the patient, one addresses what the surgery was, the emotions and the psychological state it triggered, with the aim of starting to face in a "more solid" way what will happen after discharge. Even if some "subjective" aspects emerge even before, it is only after surgery that it is possible to create specific support and counselling for the patient and thus deal with everything in a manner and aspect that is detailed and dependent on what this particular patient expresses/emerges from.
4. At Discharge, a psychological monitoring pathway is prepared which envisages at least two follow-ups at a distance of 15/30 days to understand whether a psychological/sexological/rehabilitation intervention (in addition to medical and surgical) is needed, for which the Territorial Services should be involved.
5. Possibility of referral/integration with the Territorial Services (outpatients) who will work on the various aspects listed on the previous pages.

2. Conclusions

We believe that the strong point of our work in the hospital, beyond the possibility of having a specialized psychological intervention (usually carried out by psychologists specialized in psychotherapy and sexology who are part of the Ward team and not "called" by other Services "as needed"), is the fact that we allow and facilitate an "operating philosophy" that also keeps at bay the psychological and communicative aspects towards the patient and the staff; a "psychological operating philosophy" of all the staff involved in a multifocal way in the management of the patient before and after surgery. Recognizing the psychological impact throughout gynecological surgery requires a cultural and also organizational change; it becomes a matter of public health and cultural progress towards greater respect for life, the person and the quality of care.

Compliance with Ethical Standards

Authors Contribution

All the authors contributed equally to this work: conceptualization, data curation, resources, writing
– original draft, writing – review and editing

Disclosure of Interests

The authors certify that they have NO affiliations with or involvement in any organization or entity with any financial interest (such as honoraria; educational grants; participation in speakers' bureaus; membership, employment, consultancies, stock ownership, or other equity interest; and expert testimony or patent-licensing arrangements), or non-financial interest (such as personal or professional relationships, affiliations, knowledge or beliefs) in the subject matter or materials discussed in this manuscript.

References

1. American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders. Text revision.
2. www.pavimentopelvicoinfo.it
3. Cattani, L., De Maeyer, L., Verbakel, J. Y., Bosteels, J., & Deprest, J. (2022). Predictors for sexual dysfunction in the first year postpartum: A systematic review and meta-analysis. *BJOG: An International Journal of Obstetrics & Gynaecology, 129*(7), 1017-1028.
4. Conn A, Hodges K.R. 2023.
5. Dedden, S. J., Werner, M. A., Steinweg, J., Lissenberg-Witte, B. I., Huirne, J. A., Geomini, P. M., & Maas, J. W. (2023). Hysterectomy and sexual function: a systematic review and meta-analysis. *The Journal of Sexual Medicine, 20*(4), 447-466.
6. World Health Organization. (1995). The World Health Organization Quality of Life assessment (WHO/QOL): position paper from the World Health Organization. *Soc sci med, 41,* 1403-1409.
7. Casadei, D., & Righetti, P. L. (2007). L'intervento psicologico in ginecologia. *Edizioni Scientifiche Ma. Gi. Roma, 4.*
8. Conn A, Hodges K.R. 2021.
9. Righetti, P. L., & Casadei, D. (Eds.). (2006). *Sostegno psicologico in gravidanza*. Ed. Magi.
10. Righetti P.L. Congresso "Day of Endometriosi", "Endometriosi, problematiche personali e di coppia: il ruolo dello psicologo". Azienda ULSS 2 Marca Trevigiana. 31/01/2020, Padova.
11. Perls, F., Hefferline, R. F., & Goodman, P. (1971). Teoria e pratica della terapia della Gestalt. *Astrolabio, Roma, 432*.
12. Lobb, M. S. (2001). The theory of self in Gestalt therapy: A restatement of some aspects. *Gestalt Review, 5*(4), 276-288.
13. Pizzimenti, M., & Bellini, B. (2022). *Sessuologia della Gestalt: Manuale imperfetto per continuare la rivoluzione sessuale*. FrancoAngeli.
14. Righetti P.L. Pop e sessualità: before – after surgery, "Il trattamento chirurgico dei difetti del pavimento pelvico: ciò che bisogna conosce per sapere fare", Atti Masterclass teorico-pratico 7° edizione. Ospedale Villa Salus, Hotel Voco. 25-27/10/2023, Venezia.
15. Spagnuolo Lobb M. Il now-for-next in psicoterapia. 2015. Franco Angeli, Milano.
16. Perls F. Psicopatologia della consapevolezza. 2023. Astrolabio, Roma.