Quality of Life and Factors Affecting the Response to Hysterectomy

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Hysterectomy is the most commonly performed major surgery in the United States. A hysterectomy does not produce significant psychopathology in a psychologically mature woman. Yet a mourning process occurs as a woman reintegrates her gender identity. Organic pathology, age, socioeconomic class, types of significant relationships, meaning given menses, coitus, childbearing, children, and vocational and avocational involvements are variables affecting every woman's attitudes toward, decision to have, and reactions to a hysterectomy. Each woman's characteristic coping pattern in a personally threatening situation is apparent during her hospitalization. In the process of reorganizing her gender identity, other interests (vocational and avocational) and intimate interpersonal relationships will assume new significance.

The most frequent psychopathological reaction is depression. A woman's potential for depression is increased with malignancy, predisposing personality features, a history of depressive responses to stress, and concurrent marital disruption. Data support a higher incidence of depression in post-hysterectomy than in other postsurgical female patients.

Hysterectomy is the most commonly performed major surgery in the United States (800,000 per year).[1] The number of hysterectomies has been increasing annually in the United States. If this situation continues in the future, it will result in loss of the uterus by more than half the female population by the age of 65 years. The hysterectomy rate in the United States is proportionately twice that of England and Wales.[2] These data have stimulated discussions from many sectors of American society regarding the necessity for this treatment. Its prominence as a national concern has undoubtedly prompted the recent statement of policy by the American College of Obstetricians and Gynecologists regarding "the determination of the necessity of gynecological surgery."[3]

The Executive Board of the college emphasizes that "considerations involved in such decisions include the urgency of the indications for the operation and the quality of life of the patient."[3] The criteria are as follows: *emergency situations*, eg,

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intraabdominal hemorrhage; *mandatory situations,* eg, the presence of malignancy; *urgent situations,* eg, abnormal uterine bleeding, which requires further diagnostic evaluation or definitive treatment; *advisable situations,* eg, pelvic relaxation, as with stress urinary incontinence; and *elective situations,* eg, surgical procedures to correct infertility or for family planning purposes.

The quality of life which a patient enjoys is affected by her physical, mental, and emotional health. Clues to determining the quality of the patient's life require the physician's assessment of the subjective symptoms as well as the objective findings.

Numerous factors affect a woman's reaction to a hysterectomy; this underscores the necessity for an evaluation of the total person by her physician. The purpose of this article is to assist the physician in understanding what the psychosocial factors are which influence a woman's response to a hysterectomy.

In general, the following factors are often cited as potentially negatively related to a woman's prognosis: a poor gender identity (her intimate sense of herself as a woman); previous adverse reactions to stress, particularly previous depressive episodes as a reaction to anxiety in stressful situations; depression or other mental illness in her family of origin; a history of multiple physical complaints, especially chronic low back pain; numerous hospitalizations and surgeries; age at time of hysterectomy of less than 35 years; a wish for a child or more children; anticipation that the surgery will produce loss of sexual interest and satisfaction; negative attitude of the husband or another significant person towards a woman's hysterectomy; marital dissatisfaction and instability; disapproving cultural and religious attitudes; and lack of vocational or avocational involvement. If a woman experiences many of these internal and external factors, she is highly vulnerable to serious psychopathology between three months and three years postsurgery.[4-23]*

*Additional findings noted by the author in a 1975 study of 21 post-hysterectomy women, unpublished.

The Uterus and Gender Identity

Historically, a woman's self-esteem has derived from her reproductive and family functions. Within American society there are some social classes where women are more exclusively valued for these roles. Current social changes have increased women's expectations of fulfillment outside of motherhood. In fact, the potential for an increased number of sources for status and self-esteem may change the emotional meaning of hysterectomy. Nonetheless, women vary markedly in their dependency upon the presence and function of the uterus for an adequate self-concept.

The degree to which a woman depends upon the uterus is determined by two major factors: the normalcy of its biological functioning and her beliefs about children and about the relationships between sexual intercourse and the possibility of pregnancy.

Menstrual irregularities or pain can heighten the woman's focus on her menses and the uterus. The uterus may be viewed as a burden or a less esteemed part of self. If a woman's parents or spouse perceive children as a sign of health, vigor, or wealth, then menstruation and/or sexual intercourse may be considered pleasurable mainly or only if childbirth is an eventuality. Or if a woman's mother presented the model of fatigue and unhappiness because of her "monthly illness," with a perception of children and of sexual intercourse as wifely burdens, the woman may also incorporate these concepts into her self-image.

A woman's gender identity is usually not consciously reviewed by her unless there is a specific reason for questioning her sources of self-concept. The possibility or actuality of a hysterectomy can stimulate a woman, for the first time, to consciously formulate her attitudes toward her uterus and ovaries. She finds she has definite feelings and beliefs about their anatomy, their physiology, and the value of these particular organs in her life adjustment.

Women have a variety of feelings about the cessation of menstruation. If hysterectomy occurs premenopausally, childbearing and the effects of the surgery upon sexual functioning and general physical strength and health are important. It seems logical that a premenopausal woman would mourn the sudden surgical cessation of menses regardless of the discomfort or disruption of her life

which may have occurred because of the uterus. Furthermore, she may retain fantasies of the uterus and ovaries no matter how dysfunctional and diseased they might be. On the other hand, some women express relief at the removal of a uterus and adnexa which have shown evidence of anatomical pathology when there is actual proof of previous problems (such as infertility or pathological menses). These findings relieve the guilt for feelings of abnormality. But the question about loss of gender identity is still present even for a woman who has demonstrated organic pathology. The pathology may have served to heighten the awareness that the uterus and ovaries did exist, and even the distressing symptoms may be missed and mourned through dreams, fantasies, and sensations similar to those ascribed to a phantom limb.[24*]

Socioeconomic Class, Vocation, and Avocation

In spite of the fact that the majority of women under age 50 are employed, data are needed about the relationship between employment and the reaction to hysterectomy. It may be that negative reactions are alleviated by part-time or full-time employment, volunteer community involvement, and the personal satisfaction that comes from these activities.

For the purpose of contraception, educated and/or middle class women with children are more apt to request or agree to a hysterectomy than lower class or minority group (Black and Mexican) women. Rodgers and D'Esopo point out that an active, financially secure woman, who has completed her family, seeks a hysterectomy. On the other hand, there is some evidence that minority group women, who are evaluated in large municipal hospitals, are encouraged to have a hysterectomy.[1,23] The former group of women are less likely than the latter to link the presence of the uterus with sexual function and general physical health. There is a direct correlation between socioeconomic class and the sense of relief from the negative, confining, and disruptive effects of pelvic pathology on a woman's life.

A small (21 women) study by the author supports the fact that socioeconomic class and vocational/avocational involvement positively affect surgical outcome. Nineteen of the women felt better after the hysterectomy than before it (18 of the women were married; all of the single women were employed; all of the women were middle and upper middle socioeconomic class). With four exceptions, the women had a hysterectomy between the ages of 40 and 50 and were operated on because of benign myomata, menorrhagia, and metrorrhagia. (Two women were less than 40; two women were over 50.) Eighteen of the women were employed full time or part time; the other three women were involved on a voluntary basis in community projects. The spontaneous expression of feeling "better than ever" and "glad to get it over with," as well as the relief from fear of pregnancy, enabled the women to invest themselves in, and find gratification from, vocational and avocational interests. For these women, the uterus was no longer as highly valued as during their childbearing years. They had other sources for self-esteem which had, at times, been limited in the past by child care or by the internal sexual organs' pathology.

On the other hand, minority group women express more concern about the effect of surgery upon their general physical health and upon their marital relationship, the major bond of which is viewed as coital.[23] A woman's apprehension about losing her husband to other women, for example, can lead to postponing the hysterectomy, sometimes for six to eight years. This apprehension is most common in Mexican-American women.[23]

Intimate Personal Relationships

Although the equating of the presence of the uterus with an adequate sexual relationship is probably most common in certain ethnic groups and the lower socioeconomic class, the concept of the uterus being important in maintaining sexual function is found in women of other socioeconomic strata as well.[25,26*] Some women verbalize a fear of losing sexual desire, responsiveness, attrac-

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tiveness, and the ability to gratify men. Anxiety about sexual appeal may be expressed by statements about feeling "sexier" or "oversexed" after the hysterectomy. Women who express these feelings may comment that they cannot leave their husbands (men) alone. Therefore, they increase their seductive behavior toward men as one form of reassurance about their femininity.

The reaction of a woman's husband or a significant other person to her hysterectomy is important in the woman's psychological recovery from surgery. If a woman describes her significant man as distant, detached, denying concern for or interest in her feelings or thoughts, or if he is of the opinion that she is less sexually attractive, she is more apt to be depressed than if he is emotionally supportive and understanding, and if he continues to find intercourse enjoyable, if not improved.[4,18,25]* Depression may occur even though the woman has many other valued aspects of her life (children, friends, and a profession).[6,7]*

Surgery and Aftermath

Preoperative and Postoperative Anxiety

Researchers agree that both high levels of anxiety and absence of manifest anxiety by a woman preoperatively are foreboding signs of a poor postoperative course and long-term recovery.[15] Furthermore, a woman's behavior in the postoperative recovery room is characteristic of her typical coping patterns in a maximum stress situation and predicts the characteristics of her postoperative recovery.[19,27] For example, a woman who is normally controlled and who usually assumes the leadership role will become an ally of physicians and nurses, and she may direct them; a woman who uses illness to attract attention and extract sympathy may express more pain and a greater need for nursing care and general attention in the postoperative period.

Relationship Between Surgeon and Patient

The choice of a surgeon often depends upon referral from a trusted family physician, usually male, who vouches for the surgical competence and skill of the surgeon. In describing the qualities which they seek in surgeons, women invariably comment about the desirability of a surgeon whose behavior and attitudes reflect "gentleness, kindness, thoughtfulness, understanding," and an ability to discuss details of the surgery and postsurgical reactions. Furthermore, gynecological surgeons[17,28,29] write about the importance of these qualities and about listening with the third ear. Yet relatively few women (approximately one third) seek a woman physician or surgeon, according to recent as well as older studies.[30]*

Physiological Symptoms

Postoperative experiences of physical weakness, increased fatigue and need for sleep, lack of appetite, excessive appetite, bowel irregularity, and inability to tolerate certain foods have been cited as psychosomatic in origin.[6,7,11] The psychological origin of these almost universal symptoms appears to be questionable. These physical symptoms are more likely to reflect the normal physiological reaction to surgery and recovery from it.

Psychological Symptoms

The most frequent psychopathological, long-term reaction to the hysterectomy is severe depression. The depression represents the serious disruption of a woman's role and identity. It reflects a woman's inability to reintegrate herself through the mourning process and the inadequate reestablishment of significant relationships.[6-9,11,12,14,16,18,22,26]

The potential for a reactive depression is increased when malignancy of the reproductive system is found at the time of surgery. A malignancy of the reproductive system involves issues of coping with the possibility of death. Denial is difficult to maintain during chemotherapy or in a radiation treatment program. The question is then, "why me?" The woman may believe she is to blame and is being punished for past guilt-laden activities (eg, abortion, extra-marital relationships); conversely, she may project the blame onto others (eg, her

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husband for stimulating the growth of cancer, pregnancy, childbirth through intercourse, and use of birth control pills). The question for these women is one of survival. The fact that their reproductive organs may be the cause of their demise can uncover repressed ambivalence and anger about having been born a female rather than a male.

Depression is the major reason for psychiatric hospitalization following a hysterectomy. The woman who experiences a pathological depression has the following characteristics: special features in her personality structure[5,10,14,26,27]; less likely to have pelvic pathology found at surgery; a history of reacting to previous stresses with depressive episodes which necessitated psychiatric intervention[16,18,22]; and current experiences of marital disruption, typically a husband who is unfaithful and leaves the patient.[8,18,26]

Normally, the period of mourning the loss of a valued object is six to eight weeks after the loss, and the grief period is essentially completed within six months.[31] Physicians' awareness of this fact, coupled with the awareness that there is a physical basis for the woman's depressive symptoms, may account for the frequency of referrals for psychiatric intervention between six months and three years after surgery.[8,12,14,18,26] The fact that many psychiatric hospitalizations are attributed to a hysterectomy which occurred two to five years previously could reflect the time required for disintegration of the marriage and/or the sequelae of other social and vocational factors. Another consideration is the possibility that there is no significant relationship between the hysterectomy and the psychiatric hospitalization, but rather that this surgery is only one of many surgeries and hospitalizations which indicate the woman's inappropriate involvement with body sensations and functions.

Symptoms of depression include agitation, insomnia, crying spells, weakness, fatigue, lack of appetite, and bowel irregularities.[6,7,11,21] Women with chronic pelvic pain or low back pain and no organic pathology have been described by Castelnuovo-Tedesco[10] as having the following characteristics: immaturity, alcoholism, and a childhood marked by maternal deprivation which resulted in feeling unwanted, isolated, and lonely. As adults, these women have difficulty establishing more than fleeting, casual relationships. Promiscuity is a prominent feature of heterosexual relationships. These women have even greater difficulty in forming relationships with other women. Chronically afraid of and preoccupied with thoughts of cancer and death, the symbolic expression of their separation anxiety, they long for the closeness which eludes them. These women's sexual and childbearing behavior is a defense mask which, when removed, reveals the basic oral dependency character structure. Lacking the fundamental early trust relationship and subsequent separation and individuation, they have assumed sex-stereotypic gender roles. Once deprived of the organs which both symbolize the role and give it authenticity, the women are a "shell," a term they frequently use to describe themselves. They have been diagnosed as having a hysterical, schizoid or pseudoneurotic character structure.[10]

Comparison of Hysterectomy with Other Surgeries

More post-hysterectomy women than post-cholecystectomy women require medication by their family physician for depression[22] or referral for psychiatric outpatient treatment.[8] The rate of depression in post-hysterectomy women is reported to be 2.5 times that of post-cholecystectomy women. But reports of the frequency of depression in these two groups varies markedly: from 7 percent[8] to 70 percent[22] in post-hysterectomy women and from 3 to 30 percent of women with other surgeries (the majority of which were cholecystectomies). Methodological limitations pose problems for comparisons and interpretation of studies. Nevertheless, the data support the view that depression occurs at a higher rate for post-hysterectomy women.

Psychiatric hospitalization does not appear to be significantly increased by the type of surgery. Bragg has conducted the only large-scale study of psychiatrically hospitalized women who had had either a hysterectomy (1,601) or cholecystectomy (1,162).[9] He concluded, "The risk of admission to a mental hospital following hysterectomy was greater than that following cholecystectomy, but not significantly so." This risk was higher for the age group 30 to 39. There was no significant difference in the observed and expected number of ad-

missions for psychosis for the hysterectomy and cholecystectomy groups. Diagnostic categories other than the psychoses account for the excess admissions observed in the hysterectomized group. The hysterectomy patient remains in the mental hospital on an average of almost five times as long as the cholecystectomy mentally hospitalized patient. Hysterectomized patients are likely to have a family history of mental hospitalization, whereas cholecystectomy patients are unlikely to have a family history of mental hospitalization.[9]

The incidence of mental hospitalization or request for outpatient psychiatric care has been compared between women who have a hysterectomy and those who have a tubal ligation as a contraceptive procedure. Theoretically, women should be less emotionally disturbed by tubal ligation. The reports to date yield equivocal results.[32,33] Very few studies of hysterectomized women specify whether only the uterus was removed or the surgery included a salpingo-oophorectomy. Thus, the psychological and physiological implications of the type of gynecological surgery await clarification.

Finally, some women's insistence upon a hysterectomy complicates the current knowledge and understanding of the relationship between psychopathology, psychiatric hospitalization, and the surgery. In these instances, the surgery may not be the direct cause of psychiatric care. It may instead be an indicator of the woman's decreasing ability to maintain her personality structure. For such a woman, psychiatric treatment might have occurred with or without surgery, although the surgery may hasten the woman's psychological decompensation.

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