

THE PSYCHOLOGICAL EFFECTS OF HYSTERECTOMY

George Alfred Savage

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of the requirements for the degree of  
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HALLELUJAH TO HYSTERECTOMY

or

(Let's stop talking about Sex and Do something about it).

---

Speak to me not of birds and bees  
Of the passion of flowers keep mum  
About the amorous habits  
of snakes and rabbits  
I prefer from now on to stay dumb.

In my day I have functioned with no little success  
As a human producer ad nauseam  
But my last trump is played  
I was recently spayed  
of the vital organs which causeum.

In future, my thoughts will be mostly concerned with  
Things - spiritual, social, intellectual!  
Three cheers! Jubilation!  
I'm past pollination  
With a brand new outlook sexual.

I can plan strenuous trips anytime of the month  
I can tweak my husband at random  
To that Doc with a knife  
Who has so changed my life  
A magnum of brandy, I'll hand'm.

All I can say to my gal friends is this...  
Hysterectomy's the one bed of roses  
For gals over forty  
Who, tho' still feelin' sporty  
Loathe the contraptions of Bessie Moses!!

By a patient of  
Dr. Edward H. Richardson Jr.  
in Utian (1975).

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ABSTRACTThe Psychological Effects of Hysterectomy

Hysterectomy is one of the most common forms of surgery to which women are likely to be exposed. The emotional sequelae of this procedure have long been an area of concern for the clinician. This has resulted in the gynaecologist as "uterus remover" being concerned in research of the effects of this operation.

The chief objective of this dissertation was to review the literature on the psychological effects of hysterectomies. This has revealed that women who undergo this procedure do manifest concrete changes in their functioning, attitudes and behaviour. These findings are illustrated by the use of empirical case material.

Since this operation was first performed there has been a difference of opinion about the indications for and sequelae of it. The most frequently occurring adverse effect was found to be that of depression, necessitating referral to a psychiatrist. The difficulties of delineating factors that might be predictive of a woman's reaction and adjustment to this operation and the role that a psychologist can play in this area was discussed. Methodological problems inherent in research of this nature and its implications on future studies is presented.

Empirical case studies used to illustrate issues discussed was appended.

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## 1. INTRODUCTION

"Knowledge is of two kinds. We know a subject ourselves, or we know where we can find information upon it."

Samuel Johnson, Life by Boswell, April 11, 1775.

### 1.1 Introduction

In all areas of human endeavour, we have been experiencing rapid change over the past decades. Gynaecological surgery is no exception with new procedures being adopted and old ones abandoned. Hysterectomy and some of the changes in attitude by medical practitioners regarding it are reviewed below.

A hysterectomy is an operation for the removal of the uterus. Technically the operation is seen as one of the safest major abdominal procedures and is relatively easy (Jeffcoate, 1957).

In 1890, Kraft-Ebbing quoted in Meikle et al., (1977) emphasised the psychological importance of the uterus to women by saying that while she retained it the woman has some assurance of her potential capacity to reproduce and when this potential is removed, emotional damage is likely to follow. Furthermore, Jeffcoate (1957) emphasise that her potential fertility is evidenced for the woman by way of menstruation.

There have since been many reports on the effect of this procedure. For some women it heralds relief from uncomfortable physical symptoms, while for others there occur adverse psychological sequelae (Richards, 1974; Manzer et al., 1957; Barglow et al., 1965; Raphael, 1972; Linderman, 1941; Patterson and Craig, 1963; Drellich and Bieber, 1958).

Field's study on the relocation of Boston slum dwellers, quoted in Parkes (1978), revealed that the relocated persons experienced symptoms similar to those experienced by bereaved persons. They manifest feelings of grief stemming from the painful loss, continued to long for their old homes and showed general symptoms of psychological loss. In other words, they went through a period of mourning.

The question can be asked whether hysterectomised women undergo a similar period of mourning. Reports indicate that not all women complain of adverse effects, some express a degree of satisfaction and pleasure that the symptom-producing organ has been removed. Mrs. J. (Appendix A, case no. 3) was pleased that her uterus had been removed and has reported no ill effects. In contrast, Mrs. T. (Appendix A, case no. 5) reported that she felt that the operation had ruined her marriage.

Jeffcoate (1957) describe 7 types of hysterectomy

(i) Total Hysterectomy

This involves the removal of the whole uterus including the cervix.

(ii) Sub-total Hysterectomy

In this operation, the vaginal part of the cervix and a variable amount of the supra vaginal cervix are not removed.

(iii) Pan Hysterectomy

This is an old term, the meaning of which causes confusion. Some use the term to mean the removal of the fallopian tubes, the ovaries as well as the whole uterus, while others regard the term as being synonymous with total hysterectomy. Because of this confusion the term is no longer in use.

(iv) Wertheim's Operation

This procedure is also known as an extended hysterectomy or a radical hysterectomy. This operation is performed as a primary form of treatment of carcinoma of the cervix and involves the removal of the whole uterus, the upper half of the vagina and the appendages. The broad ligaments with their cellular tissues and the lymph nodes around the iliac vessels and on the lateral pelvic walls are also excised.

(v) Abdominal Hysterectomy

This is a total or sub-total hysterectomy carried out through an abdominal incision.

(vi) Vaginal Hysterectomy

Here the approach is through the vaginal vault and the operation is nearly always of the total hysterectomy type. The tubes and ovaries can be removed as well if the need arises.

(vii) Schauta's Operation

(Radical vaginal hysterectomy) This operation is also a primary form of treatment of carcinoma of the cervix but is less extensive than the Wertheim's procedure as far as lymph node excision is concerned

It is generally agreed that this operation is a major event in the life of a woman. Why this procedure affects some women differently from others has not been well established. It will be shown below that there are many areas that need further research.

## 1.2 The Objective of this Present Study

From the earliest days of medicine the uterus has been a source of interest. The Greeks explained emotional disturbances in women by the theory that the womb had somehow become transplanted. The term "hysteria", i.e. the wandering of the uterus, was coined to describe nervous conditions in women which were accompanied by the expression of strong emotions (Raphael, 1972; Abse, 1966).

In Plato's *Timaeus* we read that, "the womb or matrix of women...when remaining unfruitful long beyond its proper time, gets discontented and angry and wandering in every direction through the body...drives them to extremity, causing all varieties of disease" ( Abse, 1966). Today, modern surgery is responsible for the wandering of the uterus out of the body altogether! The psychiatric implications of the "emigration" is the subject of this thesis.

By means of a review of the literature and the use of empirical case material the various effects of this operation are considered. An attempt is also made to demonstrate that the psychologist as psychometrician and diagnostician has an important rôle to play in the identification of emotional difficulties. It is also hoped to demonstrate that there is a need for more concentrated research on some of the many questions remaining unanswered. Greater specificity is aimed at by excluding material from this study in which operations are performed as a life saving measure in cases of malignancy.

The difficulty and dilemma of the researcher in this area is summarised by Rogers (1950). He says that gynaecologists are too concerned

about treatment and pay too little attention to aetiology. "Many women present gynaecological symptoms without being gynaecologically ill. Their illness represents a psychic conflict sailing under a gynaecological flag".

### 1.3 Hysterectomy and the Psychologist

Most of the research in this field has been done by non-psychologists because traditionally, the psychologist is not a member of the gynaecological team. In the United States of America this operation has already surpassed tonsillectomy and appendectomy in terms of numbers performed annually. It is estimated that by the age of 75 years, 19.1% of all American women would have had the operation. (Cole and Berlin, 1977; Worsley et al., 1977; Richards, 1973; S.A. Med. Journal ed., 1978).

In 1965 at the Groote Schuur Hospital, Cape Town, 5394 gynaecological operations were performed of which 630 (11.7%) were hysterectomies. In 1978 there were 5284 gynaecological operations performed of which 752 (14.2%) were hysterectomies. In 1979 the number of gynaecological operations had increased to 5298 of which 830 (15.7%) were hysterectomies. On the basis of these records from one hospital, it would seem that there is a steady increase in the total number of hysterectomies performed (Dept. of Obstetrics and Gynaecology, Annual reports, 1965, 1978, 1979).

Worsley et al., (1977) reports that many gynaecologists have long recognised that a proportion of their patients suffer from emotional disturbances which may often be associated with the presence of social problems. Accurate identification of such disturbances can be an extremely important factor in the management of these patients. Non-recognition could have serious effects in that inappropriate surgery might be performed.

The psychologist as one who is trained in psychometrics and diagnostics can play an important rôle in the identifying of such conditions and in aiding the surgeon with the difficult decision whether to refer the patient for psychiatric help, to operate, or both.

Reports on the psychological sequelae of this procedure range from mild (Dodds et al., 1961; Munday and Cox, 1967; Meikle et al., 1977; Patterson and Craig, 1963) to fairly severe (Richards, 1973; Barker, 1968; Melody, 1972). There is sufficient evidence that for some women this event may produce a crisis situation. The reasons why this should be the case is at best speculative. For these women the opportunity to ventilate their anxieties is of positive value. An unknown factor however is the nature of the support that will be most useful to the patient and how the absence of this support leads to psychological ill health (Raphael, 1972; Ananth, 1978). This is an area where the psychologist could usefully attempt to answer these questions through research. A search of the literature has failed to reveal any current or past research dealing with this specific problem.

A patient's calm acceptance of the need for this operation is no guarantee that emotional problems will not ensue. This has given rise to the ever increasing need to identify the "at risk" population at an early stage so that adequate and satisfactory preventative measures can be taken (Chynoweth, 1973; Wolf, 1970). Cases nos. 6 and 7 (Appendix A) could serve to illustrate this point. Both these women stated that they were satisfied with the operation. Mrs. S.S. (Case no. 6), a 43 year old, childless, married woman stated that she felt she was being punished by God for being childless,

yet she reports that she has fully accepted the fact of the operation, "Ek is dood tevrede" (I am completely satisfied). An unknown factor in this case is whether her guilt feeling will cause emotional problems at a later stage. Mrs. O.H. (Case no. 7) reported that she felt hurt when told she had to have a hysterectomy, yet she reports that she has accepted the fact that her uterus has been removed. However, the possibility that there is denial in such cases should not be ruled out.

Early identification of the patient who will need psychological help is aimed at. It is neither practical nor desirable to submit every patient to a psychiatric examination because of the possibility of the introduction of iatrogenic reaction by the over-emphasis of emotional difficulties or anxieties (Chynoweth, 1973).

It has been indicated that the psychologist can play an important rôle in this area. This involvement however raises many questions that only seem to emphasise the need for further research. The most important question would be how and when to collect the relevant data. The next question would be "how is the data to be evaluated?" After which we would ask questions of psychological defences which may have developed in response to the trauma of the operation and whether these defences should be explored or not.

Cases 1, 2 and 3 (Appendix A) are illustrative of this point. All three women stated that they were happy to have had the operation despite the feelings of depression after the operation.

The question about the mourning process raised above can be repeated here by asking whether the women reported in cases 1, 2 and 3 have

undergone a mourning process and have now accepted the loss. If this is the case, what factors enabled them to mourn and how can this information be utilised.

It is clear that these are questions that can only be answered by further research.

#### 1.4 The Plan of the Present Study

Having defined the term hysterectomy and discussed the rôle of the psychologist, a historical review of the development of the various schools of thought concerning the operation is given. This is followed by an account of the reasons for performing the operation.

This introduction is followed by a discussion of the contribution of psychiatry to gynaecology and a detailed account of the effects of the operation.

Finally, in the concluding integrative overview there is a discussion of some of the methodological errors, areas omitted from the reviewed studies and possibilities for future research.

There is a glossary of medical terms and the case histories are contained in an appendix.

## 2. HISTORICAL BACKGROUND

"In short, year after year the same  
Absurd mistakes went on,  
And when I died, the neighbours came  
And buried brother John!"

H.S. Leigh, The Twins  
st. 4.

### 2.1 Introduction

Gynaecological surgery has undergone a series of changes with some of the controversies still present to this day.

This lack of agreement can really only be understood by looking at the historical background and the development of the various attitudes towards this procedure.

Brief accounts of the history of gynaecology have been given by Tyrone (1952), Wright (1969) and Johnson et al., (1956). Advances in general surgery such as the sophistication of transfusion techniques with the use of whole blood, the use of non-absorbable and absorbable sutures and the discovery of antibiotics have simplified the practice of gynaecology and improved its morbidity and mortality rates (Tyrone, 1952; Wright, 1967).

### 2.2 The Development of Attitudinal Changes

Attitudes about this procedure have passed through various phases, ranging from frank opposition to a whole-hearted acceptance with variations in between.

#### 2.2.1 Opposition

The first deliberate hysterectomy was performed in 1853 and for several years it was regarded (as was McDowell's epoch-making ovariectomy) as out-

raging "fundamental principles of medical morality" (Johnson et al., 1956). In 1886, H.P.C. Wilson is reported to have told the American Gynaecological Society, "I shrink and have a feeling of terror come over me when I find myself obliged to do a hysterectomy" (Ibid.). A strong critic of the operation is found in the great ovariectomist Keith, quoted in Tyrone 1952, who could "hardly imagine that any symptom would justify the performance of a dangerous operation like hysterectomy for a mere fibroid". Furthermore he states that because 10% of his hysterectomies were sooner or later followed by insanity "is enough for me to condemn any operation that removes these organs". (Tyrone, 1952; Brit. Med. Journal 1889, correspondence).

### 2.2.2 The Relationship Between Pelvic Diseases and Insanity

The next phase centres around the aetiological relationship between pelvic diseases in women and insanity.

Roché (1897) reported that he found 60% of institutionalised women suffering from some form of abnormal condition of the pelvic organs. He further quotes Davenport who found that 80% of the women who were admitted to the Illinois Eastern Hospital had had local pelvic disease requiring treatment. In support of his claim, Roché provides a summary of 34 gynaecological operations performed on psychotic women, including 3 (8,8%) hysterectomies with the following results: 11 (32%) complete physical and mental recoveries, 9 (26%) improved, 11 (32%) unimproved and 3 (9%) deaths. These results were replicated by Hobbs (1897) who, of a sample of 80 cases, reported a recovery rate of 30 (37,5%) with 18 (22,5%) considerably improved, 28 (35%) unimproved and 4 (5%) deaths. Of the 80 operations there were 12 (15%) hysterectomies.

These results could however be questioned in the light of the fact that the authors do not provide comparative data on the occurrence in the general population of the various conditions for which they operated. Furthermore, they do not comment on the relationships between the time of onset of the pathological condition and the mental symptoms. Further criticism of these results is raised by Russel (1897) when he says that the improvement in the mental condition of the patients could be attributed to the improved hygienic conditions and the good nursing that patients received. He further argues that with sufficient staff to treat all the patients in this way the cure rate would increase generally. He also suggests a follow up period of at least two years before any claims of recovery can be made.

### 2.2.3 Opinions about the Effects of the Operation

Developing alongside the above arguments were differences of opinion about the psychological effects of this procedure. Bantock (1899) disagrees with Keith who reported that 10% of his hysterectomy patients were followed "sooner or later by insanity". He and Tait (1889) hold views directly opposite to those of Keith. Of the 101 operations performed by Bantock only 1 (1%) suffered from insanity while Tait reports 13 cases where the operation has "cured" insanity. He further makes the observation that the toxic effects of the anaesthetic is a bigger contributor to post-operative insanity than the surgical trauma. In support of this assumption he quotes an impressive record of between 7 000 and 8 000 operations and a further 3 000 cases requiring anaesthetic for reasons other than surgery and reports 7 (0.6%) cases of "insanity". He furthermore states that these cases were "sequent" and not necessarily "consequent" to the procedure.

These opinions gave rise to greater attention being paid to the rôle of the psychiatry in gynaecological practice. During the late nineteenth century and early in the twentieth century much observation, research and discussion was directed at the relationship between disease and the female generative organs by gynaecologists and psychiatrists (Barnes, 1916). The areas that received the greatest attention were the diagnosis and implications of post-operative psychosis, functional pelvic pain and the concept of the total personality approach in treating women presenting with gynaecological complaints (Da Costa, 1910; Washbourne and Carns, 1935; Mayer, 1937; Bennet, 1946; Stengel et al., 1958; Benson et al., 1959).

The impact of psychiatry on gynaecology is dealt with in greater detail below.

#### 2.2.4 An Increase in the Popularity of the Operation

The next phase in the history of this operation is the increase in its popularity to the extent that in 1893 an eminent gynaecologist, Mundé protested against "so much hysterectomy". He further warned that if the operation were performed for every fibroid identified, "very few women of middle age would still possess a uterus".

Furthermore Emmert in 1895 stated that the abuse of the operation was due to the ease of the procedure (quoted in Tyrone, 1952). It is this increase in popularity that has led to the two opposing attitudes that exist to-day.

#### 2.2.5 Current Attitudes

There are acrid and vigorous debates by eminent surgeons about the

indications for performing a hysterectomy. Some regard the large number of operations performed as unnecessary and as a "surgical racket" (Miller, 1946; Doyle, 1953; Miller, 1953). In contrast to this opinion, Wright (1969) categorically states that "the uterus has but one function: reproduction. After the last planned pregnancy, the uterus becomes a useless, bleeding, symptom-producing, potentially cancer-bearing organ and therefore should be removed."

Popular women's magazines urge women not to submit to this operation blindly but to seek a second opinion. Wasserfall (1979) suggests that the decision to have the operation should be the woman's and not the physician's. She further argues that if the woman elects to have the operation the adverse effects are less traumatic or absent altogether.

In 1971, Wright is reported to have concluded a meeting of the American College of Obstetrics and Gynaecology by saying that hysterectomies as a method of sterilisation had "arrived" (Cole and Berlin, 1977). The authors further felt that the increase in the number of operations in America was due to the greater use of elective hysterectomies as prophylaxis for uterine neoplasm, conception control and control of menopausal difficulties, especially bleeding. They do however caution that the adverse effects of the operation could offset any gains from cancer prevention.

The issues above have not yet been resolved. It would seem that gynaecology is now entering an era when women are having a greater say in their treatment (Burchell, 1977).

### 3. REASONS FOR PERFORMING THIS OPERATION

#### 3.1 Introduction

"What ... Give you a reason on compulsion!  
If reasons were as plenty as blackberries  
I would give no man a reason on compulsion"

Shakespeare, King Henry IV, Part 1  
ii, 4.

From the time this operation was first performed in 1853, questions were asked about the indications and necessity of the procedure. Miller (1946) and Doyle (1953) protest against the removal of a normal uterus while Jeffcoate (1957) states that the indications for this operation should be clearly defined. He advocates that the operation should only be done when more conservative methods of treatment are not likely to be efficacious.

These cautions and objections have been taken up by popular women's magazines who urge women to weigh up the pros and cons before agreeing to the operation (Wasserfall, 1979). Schiefelbein (1980) is stronger in her sentiments when she states that women are being exploited. She questions the sensitivity of men in treating women as they cannot identify with the problems of childbearing and contraception. She further quotes the American Medical Association as naming hysterectomies as being second only to knee operations on the list of unnecessary operations.

#### 3.2 The Concept of Unnecessary Hysterectomy

An examination of 246 pathological hysterectomy reports by Miller (1946) revealed that 76 (30,8%) of the extirpated uteri showed no histopathology. He felt that this was high enough to warrant further scrutiny. Furthermore, he felt that the removal of a uterus in the

absence of pelvic disease cannot be justified "any more than can the removal of the normal breast or gall bladder". In support of his criticism he further states that of the 246 women who were operated on, 46 (18,6%) had no disease of the pelvic organs on examination; 43 (17,4%) had no complaint listed and 23 (9,3%) were operated on for secondary complaints such as nervous fatigue, irritability and headache.

Doyle (1953) replicated Miller's observations using a larger sample of 6 248 cases from 35 hospitals. His observations showed a slight improvement over the situation reported by Miller. There was a drop in the number of normal uteri from 30,8% (Miller) to 12,5% (Doyle). In addition, Doyle found that 1 344 (21,5%) of the patients who had the operation had conditions and symptoms of such a nature that medical treatment and/or minor surgery would have been preferable.

Bieren and Hundley (1947) reviewed the reports of 1 701 hysterectomy specimens received by the pathology department of the University of Maryland School of Medicine and found that 300 (17,5%) were reported as normal. Of these they reported that in 43 cases (14,3%) no indication could be found and in 197 (65,6%) the indication was questionable. They conclude that even in a well supervised teaching hospital, the operation is sometimes performed with little or no justification.

Some of the conclusions reached by Miller and Doyle can be questioned as they collected their data by the questionnaire method from a number of contributors with neither author giving any indication that there was uniformity of definitions.

### 3.3 When is this Operation Indicated?

There appears to be some confusion about when this operation is indicated. Burchell (1977) sees part of this dilemma arising from the fact that women are becoming more concerned about unwanted hysterectomies as defined by themselves than by unnecessary operation as defined by others. He further sees that women are, through the medium of various articles, acquiring significant knowledge about their own health care and are moving to a position where they can decide on their own treatment. He says there is a shift in the woman's approach to hysterectomy with the emphasis on function rather than on pathology. Women identify these possible functions of the uterus, (i) reproduction, (ii) menstruation, (iii) sexual. There is often a conflict between the functional desires of the woman and medical indications for the operation. There may be a desire for effective contraception while retaining the potential to reproduce. A hysterectomy will result in the stopping of cyclic bleeding which for some women is evidence of good health and their femininity. Of the small sample of women who were questioned about their attitude towards menstruation most of them reported that for them it was evidence of their good health and femininity (Appendix B).

The whole concept of the functional approach breaks down if the patient does not clearly express her wishes or finds it difficult to state her desires in a way which can be quantified.

### 3.4 Indications for the Removal of a Normal Uterus

It was in response to the severe criticism levelled at gynaecologists about the seemingly irrational practice of removing an organ which was

anatomically sound that D'Esopo (1962) set out to re-evaluate the situation. In a study in which he clearly states his definitions and criteria he singled out 450 (15,4%) of 2 930 hysterectomies for further careful study. After careful categorization he concludes that in the majority of the 450 cases the operations were unnecessary, in that more conservative methods of treatment could have been used. However he continues that the removal of an anatomically normal uterus does not necessarily constitute an unnecessary hysterectomy.

The situation is further complicated by the fact that the operation may be unnecessary but asked for by the patient. The conclusion that one comes to is that there is no clear list of indications for this operation on which the physician can base his decision. He has to weigh function against pathology before finally deciding (Burchill, 1977).

A discussion of the medical indications for which this operation is performed is beyond the scope of this thesis. A detailed list is however given and discussed by Bieren and Hundley (1947) and D'Esopo (1962).

### 3.5.1 Hysterectomy and Sterilization

It is only when the perfect contraceptive has been discovered that hysterectomy and tubal ligation will no longer be the method employed for birth control (Norris, 1964; Hampton and Tarnasky, 1974). Involuntary sterility engenders feelings of inadequacy, fear, disappointment and hopelessness in the infertile couple. Treatment here is directed at (a) correction of the problem where possible, resulting in the birth of a child, (b) an accurate and thorough evaluation leaving the couple in no doubt as regards aetiology and chances of

correction, and (c) recognition and support for the emotional problem (Rosenfeld and Mitchell, 1979).

Unlike other surgical methods of birth control, hysterectomy is invariably permanent, and cannot be reversed. A woman who later regrets this choice of sterilisation then needs help in coming to terms with it. It has been found that the younger woman is more prone to suffer adverse psychological effects and also the woman who presents with a request for reversal of the procedure (Smith, 1979; the Brit. Med. Journal, Ed. 1977). However, when women who have a high risk of carcinoma in situ, or those who are mentally retarded, present for sterilisation the operation of choice, because of its permanant is a hysterectomy (Whitelaw, 1979).

### 3.5.2 Indications for Sterilisation by Hysterectomy

Muldoon (1972) quoted in an editorial of the British Medical Journal (1977) found that about 10% of women who had been sterilised had to undergo a hysterectomy within 10 years after the operation. The editorial also quotes Chandler who found that half of a group of women aged under 45 years who had hysterectomies had already been sterilised. Some authors argue that because of its certainty, hysterectomies should have a greater role in sterilisation (Whitelaw, 1979). In contrast to this view, Hampton and Tarnasky (1974) argue that while a hysterectomy ensures sterility as well as the removal of a potentially disease-bearing organ and eliminates menstrual inconvenience, tubal ligation is to be preferred. This operation they say, is less extensive and less expensive. Furthermore they found that in a comparison between 55 tubal ligation patients and 56 hysterectomy operations for sterilisation, there was little difference in the psychological aftermath.

The indications for sterilizations can be classified as for (a) medical reasons (b) obstetric, (c) eugenic, (d) socioeconomic and (e) post partum (Boulware et al., 1954; Whitelaw, 1979).

### 3.5.3 Patient Reaction to Surgical Sterilization

(with particular reference to hysterectomies)

All surgical procedures on the reproductive tract will leave an impact on the total emotional life of the woman. The effect could be psychological, physical, general ill-health or general dissatisfaction (Barglow, 1964; Barnes and Zuspan, 1958).

The need to identify the woman at risk is complicated by the lack of uniformity in that the patients can be grouped into those on whom the procedure is performed during the puerperium and those on whom the operation is performed together with the termination of pregnancy (Smith, 1979).

There are reports that a large proportion of patients who were sterilized by means of tubal ligation were pleased that they had the operation (Whitelaw, 1979; Norris, 1964; Barnes and Zuspan, 1958; Hampton and Tarnasky, 1974). In contrast to these findings Ellison (1964) reports that of the 765 new patients admitted to the Heathcote Psychiatric Hospital, 75 (9,7%) had undergone sterilization by means of hysterectomy or tubal ligation. He further specifies that of the hysterectomy patients in 30 cases (40%) there appeared to be no relationship between the operation and the mental illness. However in 25 (33,3%) of the patients there was a close relationship between the operation and the onset of mental illness. He reported that the predominant symptom was that of depression.

It would seem that the effects of this operation, whether done for sterilization or other reasons, are similar. The differences in the reports on the effects when it is done for sterilization highlights the need once again for further research. In particular, the spouse reaction to sterilization needs to be investigated. Also of importance is the investigation of the processes leading to the decision to seek sterilization and the processes of integrating the loss of reproductive capacity into the body image (Schwyhart and Kutner, 1973).

#### 4. PSYCHIATRY AND GYNAECOLOGY

"If weak women went astray,  
Their stars were more in fault than they"

Matthew Prior, Hans Carvel.

##### 4.1 Introduction

Rohé (1897) found that 60% of institutionalized women suffered from some form of abnormal condition of the pelvic organs. Hobbs in support of these findings reported that, "...the results following operative treatment have exceeded expectations. Not only have the majority of cases treated been restored to physical health but as a consequence, in a large percentage their mental condition has been brought up to par." (Barnes, 1916). These findings were criticised by Russel (1897) who felt that the improvements could be attributed to the attention the patients received.

For many centuries the uterus has been implicated in the personality of woman. It was Allbutt who in 1884 said "...a neurologic woman seems thus to be peculiarly unfortunate. However bitter and repeated may be her visceral neuralgias, she is told either that she is hysterical or that it is all uterus. In the first place, she is comparatively fortunate, for she is only slighted, in the second case she is entangled in the net of the gynaecologist, who finds her uterus, like her nose, is a little to one side, or again, like that organ, is running a little, or is as flabby as her biceps, so, that unhappy viscus is impaled upon a stem, or perched upon a prop... Arraign the uterus, and you fix in the women the arrow of hypochondria, it may be for life" (Benson et al., 1959).

The fact that many psychotic episodes in women appear to develop most frequently at puberty and the menopause and many non-psychotic women experience some psychiatric disorders in association with menstruation and pregnancy has led to the long-held belief that pelvic disorders are the chief cause of female insanity (Barnes, 1916). It is noteworthy that Miss P. (Case no. 16 Appendix B) became so emotionally disturbed prior to and during menstruation that she had to be admitted to a psychiatric hospital.

Russel (1897) questioned the validity of these claims saying that, "...It is against this wholesale surgical mutilation of helpless lunatics that I raise my voice, and the exaggerated claims that are made for it as a remedy for insanity". Stearns (1897) drew attention to the fact that an area that required examination was the role of heredity as a factor in the aetiology of insanity.

Theories of causation have over the years become firmly entrenched in the minds of professionals and laymen. It was hypothesised that anatomy determines psyche, that a woman was inherently a passive receptacle. Furthermore, women were regarded as masochistic by nature and that childbirth fulfilled an endogenous need to suffer. A more subtle application of these beliefs was the designation of women in a group responsible for secretarial or coffee making chores.

An attack and destruction of these shibboleths is not a denial that biological differences do exist between men and women. Women to-day are better informed and educated, necessitating thereby that the obstetrician - gynaecologist share his knowledge with his patient because

of her unique fears and needs. This sharing of knowledge enables her in part to control what is done (Smith, 1979).

### 4.3 Gender differences

Seidan (1976) in an excellent review on the subject of gender differences deals with a wide range of topics relating to women and the way they react to some of their biological functions. Areas covered include the importance and impact of menstruation, menopause, diseases of the reproductive system and coitus. Also dealt with are the effects of rape, childbirth and fertility control. Sex differences are seen by her as arising from at least the following sources:

- (i) Intrinsic biological differences that are present from birth.
- (ii) Anticipatory socialization which is cultural at the time it is taught to the child.
- (iii) Purely cultural differences in roles assigned to the sexes.
- (iv) Differential value which is assigned by culture to gender specific behaviour acting as reward from (i), (ii) and (iii) above, causing certain types of behaviours to be more thoroughly reinforced in a gender-specific way.
- (v) Further cultural elaboration of behaviours that predictably emerge as part of reactions to the more basic sources listed previously.

She concludes that the sexual and reproductive lives of women are a rapidly expanding research area of great pertinence to psychiatric theory and practice with many research questions remaining unanswered. What was previously assumed to be intrinsic to women or due to the vicissitudes of accepting or objecting to the usual consequences of

being a woman need to be re-examined.

#### 4.4 Early Theories of Mechanisms of the Relationship of Genital Disorders to the Psychoses

Barnes (1916) does not see the aetiological agents in gynaecological disorders claimed by some. He discusses some of the theories that have developed in support of this claimed relationship under the following headings:

##### 4.4.1 The Co-Ordinate, Super-Ordinate or Sub-Ordinate Character of this Relationship

It is generally agreed that genital diseases do occur co-ordinately or coincidentally with mental disorders. Gynaecologists are inclined to view genital disorder as super-ordinate while psychiatrists are wont to place it in a more sub-ordinate position.

##### 4.4.2 The Theory of Reflex Action

Basically this theory states that the primary seat of mental alienation is situated in the region of the stomach and intestines and that from this centre the disease propagates itself as it were, by irradiation and deranges the understanding. Put differently the theory states that "derangements of function or structural alterations in extracranial organs may reflexly irritate or depress the cortical functions."

##### 4.4.3 The Theory of Psychogenic Action

The role of psychogenic factors was closely investigated in an attempt to establish its relationship in the production of certain psychoses. It was postulated that faulty mental mechanisms working upon hyper-quantivalent ideational constellations are seen not infrequently to

lead to the development of a true psychosis.

#### 4.4.4 The Theory of Intoxication

The most ardent advocate of the theory that mental disorders are caused by intoxication arising from diseased conditions of the genital organs is Bossi. Griesinger, Prichard and Kraepelin also spoke out in support of this theory. Bossi, however, was the most explicit in stating the mechanisms by which the disorders cause psychosis. For him the psychosis is the expression of cerebral intoxication from the genital apparatus. He sees the menstrual discharge as a purification and hence the amenorrhoea that can accompany psychoses is the retention of toxic matter. Infectious conditions such as endometritis is the cause of cerebral anaemia or congestion with its accompanying symptoms.

Bossi attributes practically all psychoses in women to gynaecological disorders, a view that has been severely criticised recently by both gynaecologists and psychiatrists.

#### 4.4.5 The Theory of Endocrine Action

It used to be thought that a woman was a woman because of her ovaries. However, evidence collected now shows that diseases of the ductless glands are usually plural rather than isolated and single. Bell, an exponent of this theory, states that menorrhagia is caused by the hyperfunction of the ovaries and the thyroid and that treatment consists of counterbalance procedures. The giving of an extract of pituitary and adrenal and "...perhaps add a little calcium lactate" was the advocated treatment for this condition.

#### 4.5 More Recent Trends in Psychiatric Thought

Evidence has been collected which suggests that factors such as fear influence physiological processes. Other factors that can also produce this influence are fears, hopes, wishes, suggestions and auto-suggestions. They not only produce symptoms but can produce organic changes as well (Mayer, 1937).

The many-fronted approach in respect of gynaecological problems today have resulted in techniques such as psychoanalysis, psychotherapy and direct observation being employed in an attempt to clarify and understand the mechanisms involved (Mayer, 1937; Linderman, 1941; Deutsch, 1942 and Worsley et al., 1977).

##### 4.5.1 Psychotherapy and Gynaecology

The gynaecologist is readily chosen as a father confessor because the traditional modesty barrier between patient and doctor is broken down. They are also the most logical people to consult on such matters as premarital counselling, marital maladjustment, frigidity, contraceptive problems and sterility. These are areas that can be a source of conflict for the woman. The patient's symptoms or syndrome are not to be conceived as a psychic entity, as they often serve as a point of departure. The only entity by implication is the whole patient, as any of the symptoms could be part of a general psychoneurotic or psychotic disturbance. Such a symptom is the cessation of menstruation in a manic depressive psychosis (Mayer, 1937). Rogers (1950) has aptly stated that "...Many a woman presents gynaecological symptoms without being sick gynaecologically. Their illness represents a psychic conflict sailing under a gynaecological flag."

Some of the symptoms that are influenced to a greater or lesser extent by psychic processes are amenorrhea, menometrorrhagia, pelvic pain, dyspareunia and leucorrhoea (Mayer, 1937). He further stresses the importance of understanding the patient's contemporary problems, what they find pleasurable and what causes them frustration. It is also important for the diagnostician to be aware of how anxiety can manifest in a particular patient and what factors will render her more vulnerable. He should also have the expertise to evaluate the importance of biographic facts. Further useful information will be the patient's usual patterns of behaviour and the most common defences employed. This information will enable him to form a more complete picture of the person's mode of acting.

Such an approach is only possible when a person has had specialised training. This is an area where a psychologist could render service as an advisor to the surgeon.

#### 4.5.2 Psychoanalytic Thought

Rohé (1897) and Hobbs (1897) reported a recovery rate of 37,5% and 35% respectively of the patients after surgery. Deutsch (1942) states that for a clearer understanding of a patient's reaction to surgery, four areas need to be explored, namely:

- (i) The psychology of the individual and her neurosis as well as the psychic situation which precedes an anticipated operation.

- (ii) The actual meaning of the operation per se for the person.
- (iii) The patient's emotional relationship to the surgeon.
- (iv) The post-operative reaction

Another important factor in the manifestation and conquest of post-operative anxiety is the timing of the operation, i.e. the amount of time the patient had to prepare for the operation or whether it was performed as an emergency. The term "fright neurosis" (Schrecknerose) is descriptive of a group of symptoms characterised by general irritability, sleeplessness, anxiety dreams and nightmares, attacks of anxiety with cardiac and respiratory distress with vasomotor and secretory disturbances. The dream mechanism often portrays the dreamer herself bleeding.

It is worth comparing the information from 3 of the women reported in Appendix A with particular reference to the question of dreams.

Mrs. T. (Case no. 5, Appendix A) was informed after several abortions that she had to have a hysterectomy. She reacted to this information with shock and disbelief. After the operation she became severely depressed and reported having recurrent nightmares. She would dream she had severe vaginal bleeding but was unable to do anything about it.

Miss D. (Case no. 8, Appendix A) reported that she had two dreams after her operation. In the first she had given birth to a deformed child who when it had grown up attacked her and bit her leg. In the second dream she was pregnant and complained of abdominal pain. The doctor told her that the child was busy eating its way out of her abdomen.

#### 4.5.2 The Importance of Early Childhood Experiences

An early infantile fear is that of separation, a fear of being alone or of being abandoned by mother or her substitute. There is also the fear of punishment which is centred around the sex organs, namely "castration anxiety" (Freud, 1978).

Deutsch (1942) found that operations performed in childhood left indelible traces on the psychic life of the individual. The reaction to an operation later in life often corresponded in form and essence to that of the first. The child's reaction on the other hand depends upon his psychic situation at the time of the operation. If for example he is struggling with infantile masturbation he will interpret every surgical act involving his body as an attack and punishment and will react to later situations in a similar way to the first and regard them as assaults. Alternatively he may accept the punishment passively because of his tremendous guilt. Many prolonged convalescences and depressions are connected with this surrender to the punishing forces.

Another situation is the child's death wish against some person near him with the resultant fear of his own death. The infantile conception of death is a disappearance and a staying away making it clear why the loss of consciousness in narcosis is sometimes perceived as synonymous with entering death.

#### 4.5.3 Operations as a Cause of Abnormal Mental Conditions

Deutsch makes a further observation that there are reported cases of relatively insignificant operations that were followed by manic conditions, depressions, melancholias or some psychiatric condition.

In contrast to this, psychoses were seen to have been cured or have dramatically improved after an operation. Research and observation however, has demonstrated that the observed cure was due to the non-specific effect of the operation. For many psychiatric patients, especially those suffering from depression, the operation and the suffering are seen as punishment, thereby bringing relief from the symptoms.

Deutsch reports a case of severe mania occurring after an appendectomy. This was seen as a reaction to the meaning the organ had had for her for years. It had restricted and hindered her activities for years and she herself had given it the role of guardian which commanded and circumscribed her activities. The operation had liberated her from this dictator and she experienced a manic triumph.

#### 4.6 The Importance of Early Identification of the Patient at Risk

Any surgical operation presents a well defined trauma consisting of the anaesthetic, the mechanical injury with the possibility of the removal of certain organs or parts thereof, as well as the disturbance of physiological functions. The effect of this trauma on an individual and the degree to which it actually harms the patient is at best speculative (Lindermann, 1941).

Snaith and Ridley (1948) established a psychiatric clinic within a gynaecological department and concluded that much of the neuroses with a genital background could be attributed to ignorance and faulty upbringing. They recommended that the psychiatric assessment, and, as far as possible the psychotherapy, should be undertaken within

the framework of the gynaecological department.

Deutsch is quoted by the authors and is reported to have stressed the degree of co-operation that could ideally exist between surgeon and psychiatrist. She says that the psychiatrist should be prepared to and have the courage to, give up, at the right moment, his own hope of curing the patient psychiatrically whenever the gynaecologist can eliminate an important defect more quickly. The gynaecologist must, on his part, be prepared to defer operating or withhold his hormonal treatment if the psychiatrist advises that such measures could be psychologically harmful. He must furthermore be prepared to be operated on occasions, even in the absence of demonstrable organic disease if his colleague can be reasonably sure that only the removal of the uterus or repair of the pelvic floor will finally reassure the patient and abolish her anxiety state.

Worsley et al., (1977) demonstrated the value of identifying patients with underlying psychosocial problems, which in turn is an aid in the management as far as referral for specialist psychiatric/psychological help is concerned. Using the General Health Questionnaire devised by Goldberg and The Role of Problems check list, they found that 48 (49.5%) of 97 patients could have been considered psychologically disturbed and only 6 (6.2%) of the patients indicated that they had problems other than those specified on the list. There are however, many factors that can cause role performance failure with associated psychological disturbances. These findings highlight the need for research to improve this diagnostic technique.

#### 4.7 Psychiatric Care and Gynaecological Conditions

A discussion of the psychological sequelae to this operation follows this chapter. Linderman (1941) found that 13 (32,5%) of 40 women who had had abdominal operations showed serious disturbances of their emotional adjustment with symptoms characteristic of agitated depression.

Washbourne and Carns (1935) in a study on post-operative psychosis report that two women who had received pre-operative psychotherapy did not develop a post-operative psychosis. The authors do not however give any indication or details about the form the psychotherapy took, nor do they state whether any specific areas were focussed on. The significance of this was unclear and they concede that this was an area that needed further research.

A hysterectomy heralds the removal of an emotionally important organ. One of the effects of this operation is pseudocyesis. This can be explained as the working through a fantasy analogous to the appearance of a phantom limb, following an amputation, which recedes and disappears over a period of several months. A second possible explanation is that the woman who has never been able to establish a mature object relationship may have repeated illegitimate pregnancies, or become pregnant in a last desperate attempt to hold on to an object satisfying incorporative needs. She is reluctant to relinquish the child-bearing capacity and unconsciously maintain this capacity in fantasy following sterilisation.

Lastly pseudocyesis could be seen as developing in a woman who perceives a hysterectomy as a threat to her physical integrity and she temporarily denies completely the absence of child-

bearing capacity. The "phantom-pregnancy" can be seen as a severe, often psychotic, regression, a reaction to a threatened object loss (Barglow et al., 1965; Malerstein, 1963).

#### 4.8 The Psychological Importance of the Uterus

Drellich and Bieber (1958) investigated the reactions of 23 women who had had hysterectomies in the light of their adaptation to the operation and the emotional factors related to delays in seeking treatment.

They concluded that most women attributed to the uterus one or more of the following functions:

- (i) Childbearing
- (ii) Excretion
- (iii) Regulator and controller of body processes
- (iv) Sexual organ
- (v) Reservoir of strength and vitality
- (vi) Maintainer of youth and attractiveness

Many women viewed diseases or surgery of the female genital organs as punishment for guilt laden activities involving these organs, chiefly, but not exclusively sexual activities.

#### 4.9 Other Conditions

When a hysterectomy is performed on a woman suffering from a neurosis, her reaction may be one of the following:

- (a) She develops a new set of symptoms

- (b) In her reticence toward the surgeon the patient may impulsively, in accordance with the main patterns of her neurosis, condemn him or protect his reputation.
- (c) Her reaction will largely depend on the indication for the operation (Wengraf, 1946).

#### 4. 10 Conclusion

The practical implications of the issues discussed above is illustrated by cases recorded in Appendix A.

Drellich and Bieber (1958) concluded that the uterus had some psychological significance for the woman and that she attributed one of several functions to it. This fact is worth comparing with Mrs. F's reaction when she was told that she needed a hysterectomy (Case no. 4, Appendix A). She is a 36 year old divorced woman with one child. Her previous pregnancy had resulted in a nephrotic syndrome due to severe pre-eclamptic toxæmia. A second pregnancy could have resulted in complete renal failure with possible fatal consequences for her. This woman refused to have the operation. She says that "...If I bleed, at least I am still a woman - if I don't, what will happen? If I have my uterus out I see myself with a beard. I am very conscious of my body - At 27 (the age she was first told about the necessity for the operation) without a uterus, what kind of woman will I be? Now they cannot say A... cannot have children because she has no womb". She has now formed a new relationship with a man and says that if she had had the operation "I would not have been a complete woman". An unknown factor in this case is of what value pre-operative psychotherapy would have been (Washbourne and Carns, 1935).

Deutsch has emphasised the importance and usefulness of a psycho-analytical understanding of the patient and her post-operative reactions. Mrs. T. a 39 year old professional woman has, after 5 years, still not accepted the fact that she is now sterile (Case no. 9, Appendix A). She is severely depressed, has a loss of libido and complains of feeling "leeg" (empty) inside. She has 3 children and her 13 year old son has contracted an incurable disease. She desperately wants a replacement child and had enquired about whether the effects of the operation can be reversed. She admits that a child has a significance to her that she cannot explain. She has also experienced anxiety dreams. An unanswered question is, whether in depth psychotherapy can be of benefit to this woman?

Snaith and Ridley (1948) have demonstrated that the early identification of the patient at risk can be an aid in the pre-and post operative management. The interviewer of Miss D. (Case no. 8, Appendix A) felt that she was so depressed that it was suggested to her that she seek psychiatric help. She reports that she did not want the operation as she felt that she was bewitched. She denies having received any information about the operation and feels that it was done as an act of punishment. She became severely depressed almost immediately after the operation. It is at best speculative how the knowledge that she was a patient at risk could have been used to prevent a post-operative depression.

An attempt has been made to illustrate some of the practical implications of the issues raised in this chapter. This is an area that does not offer easy answers to the questions raised and requires further detailed research to clarify them.

## 5. THE EFFECTS OF HYSTERECTOMY

"There are moments in life, when the heart  
is so full of emotion,  
That if by chance it be shaken, or into  
its depths like a pebble  
Drops some careless word, it overflows,  
and its secret,  
Spilt on the ground like water, can never  
be gathered together."

Longfellow, Courtship of Miles  
Standish.

### 5.1 Introduction

Psychoanalysis has revealed that some gynaecological disorders are often the result of emotional conflicts. If the symptoms are to be fully evaluated it is necessary to understand these mental processes (Rogers, 1950).

In all human cultures there exists some form of family grouping. The members of this group are bound together by biological means, to father and mother by virtue of birth. Parents are bound by the fact that they live together and produce children who are, in turn, bound by the fact that they are the offspring of the same mating pair (Beals and Hoyer, 1971). Part of the function of the family can be seen as (i) to pool economic resources, (ii) to support its members in times of illness and (iii) to share the tasks of child-rearing (Seiden, 1976).

A family is not only a group of people living together, it is also a dynamic entity with a life structure and institutions of its own. It is a highly organised unit with homoeostatic mechanisms for the maintenance of a tolerable stability while at the same time providing for the emotional and physical needs of its members (Olsen, 1970).

Any serious illness of one of the family members can precipitate a crisis situation within the structure in that the organised system is thrown into disequilibrium. The temporary removal of one member necessitates that roles be changed and that there be a reorganisation of the unit to ensure stability. It is for this reason that Olsen (1970) stresses the fact that the family should be included in all stages of the illness so that they can be aware of what is expected of them. This also provides an opportunity for the expression of any emotions that the illness may engender.

An emotion that is often expressed by women who have undergone this operation is what they perceive as a negative attitude by their husbands towards them (see below). Mrs. T. (Case No. 5, Appendix A) complained that her husband did not want her because "I am not an ordinary woman anymore." A similar sentiment was expressed by Mrs. T.M. (Case No. 9) who felt that her husband's attitude had changed since she had the operation five years ago.

There could be many factors contributing to this perceived attitude, one of which could be the degree of family involvement. This is an area that needs to be researched to attempt to establish the factors involved in the various attitudes expressed by the spouse.

## 5.2 The Crisis of Hysterectomy

Raphael (1972) sees the impairment of ego functions in the cognitive, defensive, affective, reality and objects relations aspects as precipitating a crisis situation for the woman post-operatively. The affective aspects are seen as being expressed as a sense of loss of

the child-bearing capacity, a loss of sexual function, the loss of menstruation, anxiety over death and the fear of damage to the body. There are also feelings of guilt, the need for punishment and depression.

The defensive elements are seen as denial, rationalisation and reaction formation. The patient's realisation of potential harm to her body relates to the object relations aspect of the crisis situation. This engenders fears similar to those experienced in childhood about parental abandonment. There is a resultant increase in the need for reassurance from love objects and from people upon whom the patient is emotionally dependent. This results in a tendency to strive for an increase in primary group cohesiveness, and relationships with authority figures has an increased value. The patient's dreams often portray the latent theme of being abandoned by love objects. Raphael sees one way of helping the woman to negotiate this crisis is to create opportunities for her to express her anxieties to people who are significant to her. In this respect the surgeon can fulfil the important role of educator by providing adequate information and explanation in an empathic supportive manner.

An unknown factor however is what the exact nature of this support should be. It is also not known how the absence of this support or how the non-resolution of the crisis situation precipitates psychiatric ill health.

The application of Raphael's criteria would necessitate that Miss D. (Case No. 8, Appendix A) be classified as being in a crisis situation. She is a 36 year old single woman who had a hysterectomy in

January 1981 for dysfunctional bleeding. The impression of the interviewer was that this person was depressed and it was suggested to her that she avail herself of psychiatric help.

This woman has expressed her distress at the loss of her child-bearing capacity and now regards herself as being sexually unattractive.

She has strong guilt feelings about this and feels that she has been punished, "now I can be a mirror for those who have children and do not appreciate them. My womb was removed as a punishment because I was too fond of other people's children."

The defence used by her could be seen as rationalisation in that she believes that it was because of her relationship with a man of a different religious group that she was bewitched. She furthermore denies that she had received any pre-operative information about the operation. Miss D. has isolated herself from friends and refuses to consider forming a relationship with a man because she has no womb.

The question of the identification of the person at risk is very pertinent in this case. Furthermore, once the crisis situation has been identified it is not known which aspect of the crisis should receive preferential treatment.

Baron (1976) on testing the hypothesis that career women would be less likely to experience negative emotional, behavioural and attitudinal outcomes following this operation than housewives, has failed to prove it. She found that well-educated, self-orientated career women did not experience the operation more positively than other women.

The findings of Baron are corroborated in the small sample in Appendix A. Mrs. V. (Case No. 11) is a 31 year old professional woman who suffered from severe depression. This was so incapacitating that she had to be admitted to a psychiatric hospital. The symptoms appeared within 6 months after the operation. By way of contrast we have Mrs. R. (Case No. 10) who is a housewife, who was also admitted to a psychiatric hospital and was diagnosed as suffering from depression with feelings of worthlessness and having taken an overdose of tablets. Her depressive feelings were of two years duration, the onset being immediately following her operation.

### 5.3 Hospital Stay and Hysterectomy

The average length of stay in hospital following a hysterectomy ranges from 6 to 14 days (Moolgaoker et al. 1976). After examining the records of 12 026 hysterectomy patients Ledger and Child (1973) found a difference in the response between American whites and non-whites. The percentage of patients with post-operative fever, of those requiring antibiotics and blood transfusions and the average length of stay in hospital was greater in the non-white patients. The reason for this discrepancy was unexplained. A possible causitive variable was the socio-economic status of the patients but for some reason they were unable to measure this.

The question of racial differences with regard to the reactions to this operation is of particular pertinence to South Africa. The only South African study included in this dissertation (Dodds et al., 1961) fails to make this distinction! A cross-cultural study to investigate the role of the breast and the uterus in feelings of femininity is presently being undertaken using mastectomy and hysterectomy

patients (Kuny, 1980).

#### 5.4 Psychiatric Hospital Admission and Pelvic Operations

Hollender (1960) postulates that the less secure a woman is in her feelings about her femininity and attractiveness, the more intense will be the need for defense mechanisms to cope with the threat to the self-image imposed by the removal of the symbolic pelvic (sexual) organ. He found that in 9 (4,5%) of 203 women admitted to a psychiatric hospital it was apparent that the pelvic operation was the precipitating factor while 5 (2,5%) were admitted following other types of operations. He stresses the importance of the woman's attitude to her uterus and child-bearing in precipitating a psychiatric illness. No reference is made to any previous psychiatric illness suffered by the women. No attempt was made by Hollender to explore or to identify factors responsible for an unfavourable response. Because of the many factors that could be responsible for the effects of this operation, it is almost impossible to predict with any degree of accuracy what the outcome of the operation will be.

#### 5.5 Psychological Effects

It is well documented that abdominal operations, in particular gynaecological operations, are especially likely to be followed by adverse psychological reactions. This response is often related to some instability of the basic personality or to a previous history of a psychiatric illness (Stengel et al., 1958; Melody, 1962; Munro, 1969; Linderman, 1941).

Any operation presents a well-defined trauma consisting of the anaes-

thetic, the mechanical injury, the possible removal of an organ or parts thereof and the disturbance of the physiological functions of the body (Linderman, 1941). Psychologically hospitalization requires the patient to surrender some authority in order to permit the medical care to take place. The patient on her part, brings to the hospital an inherent fear of death (Smith, 1979). Smith (1979) furthermore states that the effects of any operation are related to the attitude the woman holds about the procedure. He states that for some the operation is related to the concept of femininity since the uterus is the organ of reproduction, while for others the operation heralds freedom from a troublesome symptom. Furthermore, there is the woman who has completed her family, but strongly wishes to retain her child-bearing potential. In contrast there are women who submit to the operation with very positive attitudes about contraception.

Many fears surround the removal of the uterus. There is fear of a loss of strength, of changes in appearance, premature ageing and of difficulties with sexual activity. The most debilitating effect of this operation for some patients is depression (Richards, 1973).

#### 5.5.1 Depression Following this Procedure

There are reports that this operation is followed by fairly mild effects (Dodds et al., 1961; Mundy and Cox, 1967; Meikle et al., 1977) while others found that reactions were fairly severe, (Richards, 1973; Richards, 1974; Barker, 1968; Melody, 1962; Menzer et al., 1957; Barglow et al., 1965). The following cases recorded in Appendix A illustrate these findings.

(i) Mrs. J. (Case No. 3) had a hysterectomy for uterine fibroids and dysfunctional bleeding 9 months prior to the date of interview. She has 3 children and reports that the physical discomfort was such that she was incapacitated for at least one day every month with menstruation. There was no history of any previous psychiatric illness and when faced with the possibility of the removal of her uterus she felt positive about it. Her only fear was that of her possible death.

Within two months after the operation she was fully functional and has not suffered from any depression. She reports that she still feels a complete woman and the fact that she does not menstruate is seen by her as a positive result of the operation. There is no loss of libido and no menopausal symptoms. Mrs. J. reports that she has no regrets about the operation.

(ii) Mrs. W. (Case No. 1) is a professional woman with five children and had her operation three years prior to the interview for a prolapse of the uterus. Before the operation she was prone to periods of depression and within six months after the operation her depression was so severe that she required medication to relieve it. She has complained of a loss of libido and attributes this directly to the operation. Despite the fact that she felt depressed she was still able to function and reports that she is glad she had the operation.

(iii) Mrs. V. (Case No. 11) a professional woman with two children, was in her sixth post-operative month at the time of the interview. Her hysterectomy followed three years after being sterilised and was done because of recurrent infections. Within three months after the opera-

tion she became so severely depressed that she had to be admitted to a psychiatric hospital. She was hospitalized for one month and was treated with antidepressant drugs.

The three women quoted above each reacted differently to the same operation. The questions that could be asked are, why did they react the way they did; could one have predicted what the outcome might have been, and who was at risk before the operation. Linderman (1941) found that a pre-operative history of depression was a possible indication of post-operative depression.

A factor to bear in mind in relation to the depression is the life events of the patients. These could precipitate a depressive episode. Chynoweth and Abrahams (1977) quote the case history of a woman who presented with depression after having had a hysterectomy. However, careful examination revealed that she had made a satisfactory recovery from the operation but her son had been injured in a motor vehicle accident which could have accounted for her depression. In none of the cases presented in Appendix A, with the exception of case no.12 were the women asked about their life events.

## 5.6 OTHER EFFECTS

### 5.6.1 Loss of Menstruation

Jeffcoate (1957) notes that it is psychologically important for the woman to know that she is "normal" and potentially fertile. The recurrent evidence of this by way of menstruation is of great importance to her and her husband. A direct result of this operation is the ending of menstruation which in itself is seen by some women as a major event (Polivny, 1974; Meikle, 1977; Richards, 1974; Barker, 1968).

Some women are pleased to be freed from the monthly discomfort while others see it as evidence of their femininity. Mrs. S. (Case No. 2, Appendix A) had a hysterectomy because of dysfunctional bleeding. She reports that she would have preferred to have retained her child-bearing capacity but she is pleased to be free from the physical discomfort. In contrast to this attitude, Mrs. F. (Case No. 4, Appendix A) was advised to have the operation because of very real life-threatening complications that could result if she became pregnant. She has refused the operation because she does not want to stop menstruating. "If I bleed, at least I know I am a woman. If I don't, what will happen?"

Much research has been done in the area of the effects of menstruation on cognitive and perceptual motor behaviour but the paucity of work with respect to other dimensions of behaviour and the importance of folklore is startling (Sommer, 1973; Snow and Johnson, 1977).

From the answers given to the questions in Appendix B it is evident that some women experience varying degrees of discomfort with menstruation. They are however, willing to tolerate this because for them this is part of being a woman (Case Nos. 3 and 10). One woman replied that she would elect to have her periods stopped if she could have the guarantee that her fertility would not be affected! (Case No. 12). Another replied that she could see no reason why her periods should stop as it was a very necessary biological function (Case No. 11).

It is not known what mechanisms are employed by the woman to help her deal with the effect of the operation on menstruation. This is an

area that has not been researched.

### 5.6.2 The Self-Concept and the Operation

In answer to the question whether menstruation had any special significance for them, some of the women answered as follows:

"It makes me feel I am a woman," "It is an integral part of my femininity" and, "To me it is the first step to becoming a woman."

(Appendix B, question no. 10, Case Nos. 3,6 and 11).

Very strong sentiments about her femininity and the role of her uterus in this connection were expressed by Mrs. F. (Case No. 4, Appendix A)

"At 27, without a uterus, what kind of woman will I be?"

It is postulated that the outcome of the operation will *inter alia* depend on the woman's personality, her experience and interpretation of femininity and how the fact of the operation is handled by significant people in her life. Furthermore, it is felt that women with positive feminine concepts or those who have adequate support from their families and physician would be able to cope with the trauma of the operation without displaying any psychiatric symptom (Wolf, 1970).

There are women who outwardly experience this operation as non-traumatic and who adapt satisfactorily. Wolf (1970) is also of the opinion that these women may be unaware that some mechanism is enabling them to cope. Some women who deny having feelings of loss or who say that they welcome the operation may actually be hiding more significant and painful emotions.

It is interesting that Mrs. S., a forty three year old, childless married woman has reported that she is very happy that she had the operation. She married at twenty two years of age and for twenty one years has unsuccessfully attempted to have children. Her efforts included several visits to an infertility clinic and numerous investigations. Her husband however, was uncooperative in that he has refused to avail himself of any investigation. She says that she has accepted the fact of the operation and the fact that she has lost her child-bearing capacity (Case No. 6, Appendix A).

The question could be asked whether this woman has in fact calmly accepted the fact of the hysterectomy or whether this is a defence against some painful emotion. At the time of the interview this was not explored as the writer felt that this could be her way of coping with the trauma of the operation.

For this dissertation husbands were not interviewed to establish what their attitudes were regarding the operation.

Wolf (1970) found that the general attitude expressed by the husband was, "If my wife has a hysterectomy, she does not have a uterus. If a woman does not have a womb then she really is'nt a woman. Then if she really is'nt a woman, what am I if I have intercourse with her?" Wolf is of the opinion that the operation could pose a threat to the sexual identity of the man as well as of the woman. The significance of this statement had not been fully researched.

### 5.6.3 Sexual Functioning

A common complaint after this operation is that of loss of libido.

Women attribute this directly to the effects of the operation (Case Nos.

1,2 and 3, Appendix A) while others complained of this loss before the operation (Case Nos. 3 and 9, Appendix A).

Research on the effects of gynaecological surgery on sexual functions has shown that in a mature woman, the vagina becomes the centre of normal sexual excitement. It was furthermore found that in women who had experienced coitus prior to the operation, the removal of the whole uterus, all the ovarian tissue, and in one instance the clitoris, did not change the sexual reaction (Hoffman, 1950).

Utian, (1975) concluded that the loss of libido observed in hysterectomised women was probably not a biological effect but rather a measure of the psychological attitude the women has about her uterus.

Sloan (1978) attributes the libidinal loss to the dynamics of the depression which is part of the post-hysterectomy syndrome. Research is required to establish some means of identifying which factors are at work in a woman who does complain of this loss.

### 5.7 Contradictory Reports

There are researchers who report that this operation does not cause any adverse psychological effects (Patterson and Craig, 1963; Bragg, 1965; Hampton and Tarnasky, 1974; Meikle et al., 1977). In contrast to these findings there is also evidence that there are women who do suffer from emotional disturbances which could be attributed directly to the operation (Barker, 1968; Linderman, 1941; Melody, 1952; Richards, 1973).

A depressing feature of the research findings is the fact that the variables are so numerous that it is impossible to predict with

certainty what the outcome of the operation will be for a particular woman. There are some general guidelines of possible contributions to an adverse effect but it cannot be stated with any degree of certainty why this should be so, (see below). A factor mentioned by most researchers in this area is the need for more detailed studies of the variables.

## 6. AN INTEGRATIVE OVERVIEW

"Know, not just for knowing's sake,  
 But to become a star to men forever,  
 Know, for the gain it gets, the  
 praise it brings,  
 The wonder it inspires, the love it  
 breeds:  
 Look one step forward, and secure that  
 step!"

Browning, Paracelsus.

### 6.1 The Objective of this Chapter

The prime objective of this dissertation has been to review some of the literature in relation to the psychological sequelae of hysterectomies. It was also intended to highlight the need for further research into the many questions that remain unanswered furthermore, an attempt was made to show that the psychologist as one trained in psychometrics and diagnosis can make a contribution to the evaluation of gynaecological symptoms. A detailed discussion of the various effects was not aimed at.

To achieve this aim a chronological account of the changes in attitude toward the operation and its effect was initially presented. This was followed by a discussion of some of the most common reasons for performing this operation. Attention was then focused on the contribution psychiatry has made in the understanding of the dynamics of gynaecological symptoms. The value of the early identification of the woman at risk was also considered.

In the light of the above, the present chapter will initially consider the contributions of psychiatry in the understanding of the symptoms and in suggesting treatment plans. Psychiatry has furthermore attempted to put forward reasons why women react the way they do to this operation.

Resulting from this the question of future research is considered using the reviewed reports as a basis.

Finally the contribution the psychologist can make to gynaecology is considered. Where appropriate, points will be illustrated by reference to empirical case material.

## 6.2 THE CONTRIBUTION OF PSYCHIATRY TO GYNAECOLOGY

### 6.2.1 Introduction

It is clear from chapter 4 that psychiatry has exposed a vast virgin field for research. Given the diversity of sequelae and possible causes, it rests with psychiatry to suggest how these two can be matched.

It is important that the clinician treating a woman with a gynaecological complaint bear in mind that many women present with gynaecological complaints without being ill gynaecologically (Rogers, 1950).

In a busy department it is impractical to subject every woman who presents with gynaecological complaints to a full psychiatric examination. The value of this practice should be weighed against the fact that up to 70% of the women who have had hysterectomies complain of symptoms severe enough to warrant psychiatric treatment (Linderman, 1941; Melody, 1962; Munro, 1969).

In any one woman it might be possible, by an approach such as psychoanalysis, to understand the meaning of the symptoms and the operation. It is not clear however why a particular woman should resort to the coping mechanism she chooses. No measure exists that will enable the clinician to accurately predict which women will react unfavourably to the operation. The presence of (i) a previous history of psychiatric illness, (ii) a medically unnecessary operation, (iii) marital disruption in a young woman, (iv) the absence of pre-operative anxiety and (v) any misconception or fear about the operation, are regarded as danger signals for a possible adverse reaction to the operation (Polivy, 1974). It is not known how many of the above factors should

be present for an adverse effect to occur or which combination of factors has the highest risk. There are also women who do not appear to manifest any of the above criteria and still complain of adverse psychological effects. Mrs. W. (Case No. 1, Appendix A), complained of depression post-operatively without fulfilling any of the above criteria.

### 6.2.2 Depression and Somatic Symptoms

It is important for the clinician to take cognisance of how the patient presents clinically. It is widely recognised that somatic complaints are frequently encountered in a depressive illness and in some instances these may predominate in the clinical presentation (Dowling and Knox, 1964). Also of importance is the fact that a patient with a previous history of psychiatric illness is prone to suffer from a similar breakdown after a hysterectomy (Ellison, 1967; Melody, 1962; Barker, 1968; Richards, 1973). The question of cause and effect in relation to adverse sequelae to this operation is unresolved. It is also known that patients with no previous history of psychiatric illness may also suffer from adverse psychological effects arising out of this operation.

### 6.2.3 The Question of When to Operate

It was seen in Chapter 3 that there are a variety of indications for which a hysterectomy could be performed. The accusation has also been made that a large proportion of the operations are unnecessary (Doyle, 1953). This situation is complicated by the fact that the operation may be requested by the woman when there are no medical indications to justify it.

Cohen et al., (1965) found on comparing fifty patients who were diagnosed as having hysteria with a control group that the number of operations done on the hysteria patients exceeded those of the control group. There were also more gynaecological operations performed in the hysteria patients with twenty four hysterectomies compared with six and seven respectively in the control group of (i) healthy and (ii) medically ill patients (see Table 1 and Figure 1 from Cohen et al., 1965).

**TABLE 1** Comparison of Frequency of Major Surgical Procedure in Hysteria Patients and Control Subjects

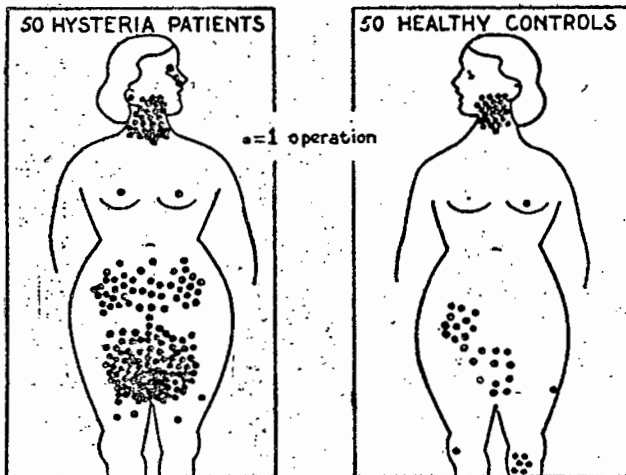
No. of patients.....	Control Patients		
	Hysteria Patients	Healthy	Ill
	50	50	80
	Rate per 100 Patients*		
<b>Operation</b>			
Gynecologic operations † .....	166	24	57
Mixed operations ‡ .....	84	14	20
Dilation and curettage.....	70	0	30
Appendectomy .....	68	28	47
Tonsillectomy .....	68	50	57
Oophorectomy .....	48	8	10
Salpingectomy .....	32	10	7
Hysterectomy .....	24	6	7
Sterilizing surgical procedures prior to age 35 .....	20	0	7
Adhesiotomy .....	18	0	0
Uterine suspension .....	16	0	7
Cesarean section .....	14	0	0
Cholecystectomy .....	14	0	17
Hemorrhoidectomy .....	12	0	7
Nephropexy .....	8	2	0
Ovariectomy .....	4	2	3
Spinal fusion .....	4	0	0
Scalotomy .....	4	0	0
Nephrectomy .....	2	0	0
Coccygectomy .....	2	0	0
Laminectomy .....	2	0	0

\* The rate includes (1) any operation on that organ (2) a reoperation on that organ, and (3) an operation on that organ done as part of an operation involving several organs. Bilateral organs, e.g. ovaries, are considered as one organ in these calculations.

† Gynecologic operations = operations involving ovaries, tubes, uterus or vagina.

‡ Mixed operations = operations involving more than one organ.

**FIGURE 1**



Comparison of number and location of major surgical procedures in 50 hysteria patients and 50 healthy control subjects. By weight it can be calculated that the mass of organs removed in hysteria patients is more than three times that in control subjects. This represents a modern "gibeath ha-araloth (Joshua 5:2)

The above authors acknowledge the difficulty confronting the surgeon when faced with a patient suffering from hysteria. They advise that these patients should never be dismissed as malingerers, unworthy of further medical attention. Furthermore, they stress the need for a more accurate diagnosis of hysteria and clearer indications for surgery.

Hysteria presents special problems in that there is a dearth of information about the specific mechanisms of individual symptoms. There is a need for planned studies with controlled observations with long-term follow-up as well as studies of therapy before a true understanding of this disease and its treatment is obtained (Ibid).

#### 6.2.4 An Illustrative Case History

Mrs. M. (Case No. 12, Appendix A) is a forty year old housewife with eight children who had her hysterectomy nine years prior to the time of the interview. She was admitted to a psychiatric hospital because of severe depression with anxiety. From her personal history it was learnt that when she was five years old she was severely burnt on the right side of her body by fire and was hospitalised for one year. She had several skin grafts from her thighs but scar tissue formation has prevented her right breast from developing. This has led to much unhappiness caused by the teasing of her peers. She still does not undress in front of people because of her poor body image. Her childhood was generally unhappy because of a disrupted family life and an alcoholic father. On her own admission she married a man nine years her senior because he could offer her an escape from an intolerable home situation.

After nine years this woman still complains that she feels "leeg" (empty) inside and that, "alles is uitgehaal" (everything has been removed). When her two teenage daughters menstruate, she deeply regrets the fact that she has consented to have the operation.

Before the operation she had suffered from depression and was generally unable to cope with life stresses. A further complicating factor is the fact that two of her sons (in whom she has made a strong emotional investment) were committed to a school of industry. This has made her feel that she has failed as a mother.

In view of the fact that she is generally unable to cope with stress, the question can be asked whether the current depression and anxiety are sequelae to a nine year old hysterectomy or to a more recent life event (i.e. the incarceration of her sons?). Given the biographical data - can one predict that she was at risk pre-operatively and that the performance of the operation should have been postponed? What role would pre-operative psychotherapy have played in the degree of post-operative psychological disturbance? Finally it could be asked, if she still has not accepted the fact that her uterus had been removed and complains of feeling empty, is the depression related to the operation or are the somatic complaints part of the dynamics of the depression? The answers to these questions cannot be found in any research that has been done to date and serves to highlight the need for further work in this area.

#### 6.2.5 Psychoanalysis and Hysterectomy

Deutsch (1942) has stressed the importance of psychoanalysis in the understanding of the symptoms following this operation. Psychoanalysis however is a costly and lengthy process and is out of reach of

the ordinary woman. The value of this form of therapy is not denied, the question however is whether similar results could be obtained by an alternative form of therapy. Mrs. V. (Case No. 11, Appendix A) could serve as an illustration.

This woman had her operation in January 1981. Her mother, with whom she had a good relationship, had died during the month of April 1980. On the first anniversary of the mother's death, she became so severely depressed that admission to a psychiatric hospital was necessary. Concurrently Mrs. V., who is a teacher, was instructed by her principal to teach music. She reports that she does not know a note of music and felt she would not be able to perform this task.

The significance of the development of her symptoms in the month of her mother's death is not known. A second question is whether her feelings of impotence at her new commitment was part of the dynamics of her depression or vice versa.

There is sufficient evidence to suggest that a hysterectomy can cause an endogenous-type depression with agitation. This depression appears to be more severe, more refractory for treatment, lasts longer and tends to recur (Ananth, 1978). The need for treatment is not questioned but the most effective form of treatment is yet to be formulated.

#### 6.2.6 Conclusions

The question is not whether this operation causes adverse psychological effects but rather which factors are responsible for such effects.

The ideal situation would be that after a careful pre-operative evaluation of the person, appropriate steps be taken to prevent or alleviate

possible problems. The degree of emotional investment in her uterus, the amount of satisfaction of her sexual and reproductive instincts and the presence or absence of emotional support are among the factors that could indicate an adverse reaction (Wolf, 1970).

The presence of certain factors in the woman's emotional and personal make-up have been associated with an unfavourable psychological reaction to hysterectomy. However, more research is needed to state with any certainty how these factors cause the adverse effect.

In the absence of relevant research findings, one can question the advice of Deutsch quoted by Snaith and Ridley (1948). She says that the ideal co-operation that could exist between the surgeon and psychiatrist is when the latter has the courage to give up his plan of helping a patient if the gynaecologist can eliminate the problem more quickly. The gynaecologist on his part must be prepared to refrain from operating or to withhold his hormonal treatment if the psychiatrist advises against such measures. He furthermore must be prepared to operate on occasions even in the absence of demonstrable organic disease, if his colleague can be reasonably sure that the removal of the uterus or the repair of the pelvic floor will finally reassure the patient and alleviate the anxiety state.

### 6.3 FUTURE RESEARCH

There are many contradictory reports about the degree of psychological disturbance caused by hysterectomy. Among the most popular methods of research in this area are:- (i) retrospective studies (Johnson et al., 1956; Howkins and Williams, 1963; Munday and Cox, 1967; Patterson et al., 1960), (ii) the questionnaire method (Raphael, 1972; Dodds et al., 1961; Baron, 1976; Richards, 1978), (iii) the operating surgeon performing his own research on his own patients (Richards, 1973; Richards, 1974) and (iv) the use of the semi-structured open ended technique of interview (Patterson and Craig, 1963; Huffman, 1950).

There have always been difficulties in controlling the non-specific effects of the surgery as well as the choice of an adequate control group. This has been a particular feature of those studies reporting no adverse effects (Meikle, 1977). Other variables to be considered include the following:

#### 6.3.1 Was the Operation Requested by the Patient or not?

A variable that was shown to have an effect on the outcome of surgery is the question, who made the original suggestion of surgery?

Hampton and Tarnasky (1974) reported no difference in the post-operative psychological adjustment between hysterectomy and tubal ligation patients. To a certain extent their patients could decide which operation they wanted. The patients studied by Barglow et al. (1965) were randomly assigned to receive either a tubal ligation or a hysterectomy. They reported that the hysterectomy group made a poorer adjustment to the operation. Ellison (1964) however emphasises that no woman in her child-bearing years should be sterilised by any

means unless every other method of contraception has been fully considered and found to be unsatisfactory. He found that both the tubal ligated and hysterectomised women may suffer from psychiatric symptoms post-operatively. The hysterectomy group may suffer from depression and the tubal ligation group from a mixed paranoid-depressive syndrome.

In contrast to these findings, Ellison states that in countries where sterilisations are legalised on eugenic grounds the operation is as a rule not followed by psychiatric disturbances. A possible reason for this is the fact that the feelings of guilt that are a feature of the operation when it is done for reasons other than eugenic are not present. These women voluntarily undergo eugenic sterilisation relieving them of the guilt of producing genetically tainted children, either as carriers or sufferers.

It is reported that between 1% and 18% of the women who had been sterilised request reversal of the procedure (Thomson and Templeton, 1978).

If viewed in isolation it would seem that women who request to have a hysterectomy have a more favourable outcome to surgery to those who do not.

### 6.3.2 The Woman's Age at the Time of the Operation

There is a wide age range during which this operation is performed, from under nineteen years to over seventy years (Johnson et al., 1956; Howkins and Williams, 1963; Munday and Cox, 1967). The depression reported in the literature does not appear to be attributed to a vulnerable age although some authors are of the opinion that younger

women are more prone to suffer from adverse effects (Richards, 1973; Adams, 1974; Wolf, 1970). Melody (1962) found the age range of the women who became depressed to be between thirty five years and fifty two years while the mean age of the fifty six women studied by Hampton and Tarnasky (1974) was 34,1 years. Of these women, eight (14,3%) suffered from depression but their mean age is not stated by the authors.

In contrast to the above, Chynoweth and Abrahams (1977) found that in the hundred and forty seven women they studied, age was not a variable that differentiated between good and poor post-operative adjustment.

Variables to be considered in conjunction with the age at the time of operation is the womans self-image and her capacity to bear children. The psychological impact of anything that interfered with the child-bearing capacity has been well researched (Ellison, 1964; Policy, 1974). An area that has however not received the same attention is the relationship between parity and hysterectomy. It is not parity per se that needs to be investigated but rather the question of the degree of satisfaction of a woman's maternal needs before the operation in relation to a satisfactory adjustment thereafter (Schwhart and Kutner, 1972).

### 6.3.3 Religious Affiliation

Attention has been given to race differences and the effects of hysterectomy, (Johnson et al., 1956). The significance of the patient's religious affiliation and her response to the operation have not been researched. Barnes and Zuspan (1958) found that patients of physicians belonging to the Catholic faith were more likely to undergo a

hysterectomy but it is not known how the patients faith affects the choice of operation.

#### 6.3.4 Design Difficulties

The fact that adverse psychological reactions do occur from operations other than hysterectomy has given rise to the problem of a suitable control group. The most frequently used has been patients who had had a cholecystectomy (Bard and Sutherland, 1955; Stengel et al., 1958; Washbourne and Cains, 1935; Barker, 1968; Brag, 1965; Linderman, 1941). It has been found that the admission rate to a psychiatric hospital was lower for cholecestectomy than for hysterectomy but a completely satisfactory control group has not been found (Brag, 1965).

#### 6.3.5 The Follow-Up Period

There are reports that patients became depressed within three months post-operatively (Meikel et al., 1977; Melody, 1962). However there are authors who are of the opinion that a follow-up period of three to five years is more realistic (Richards, 1973; Munday and Cox, 1967; Dodds et al., 1961; Barker, 1968). An important factor in relation to a long follow-up period was mentioned in Chapter 5. The case quoted by Chynoweth and Abrahams (1977) highlighted the significance of possible life events between the operation and the time of assesment that could result in the patient becoming depressed. The case of Mrs. M. (Case No. 12, Appendix A) quoted above can further serve to illustrate the importance of the life events.

It is possible that the longer the period between the operation and the assesment the greater the possibility that other variables could have influenced the results. An assesment done too soon after the

operation may yield similar results regardless of what the procedure was.

#### 6.3.6 Data Collection

A large proportion of the research relied on retrospective studies without the benefit of some pre-surgery base-line measure. This lack limits the confidence that can be placed in the results thus obtained.

Data can also be collected by means of a questionnaire. This form of research is however exposed to the possibility of patients compliance. It is also doubtful whether a woman will commit to paper truthful information about intimate questions. A list of questions and answers is contained in Appendix B. It was found that the women were reluctant to commit certain issues to paper and preferred to talk about them. In this way complementary information was obtained in an informal interview.

It would seem therefore that a greater amount of information can be obtained by means of an informal semi-structured interview. The most beneficial method of processing this information has still to be devised.

#### 6.3.7 Future Research

The multi-factorial aspect of this operation is evident from the discussion above. No one study is capable of controlling all the variables that could influence the results. There are however areas which future researchers should take cognisance of in planning their research.

- (1) There should be some pre-operative base-line measure.
- (2) Attention should be given to the psychological preparation of the woman for this operation with particular reference to her attitudes towards her uterus, menstruation and child-bearing.
- (3) The involvement of the family as a support system during the woman's convalescence is important.
- (4) In South Africa with its multi-racial society it is important to recognise that attitudes differ from culture to culture.
- (5) Data collection should be such as to minimise contamination by interviewer and/or patient; there should be a satisfactory method of processing data.
- (6) There should be a suitable control group where applicable.
- (7) The researcher should decide on a realistic follow-up period.

#### 6.4 THE ROLE OF THE PSYCHOLOGIST

In Chapter one of the dissertation the lack of involvement of psychologists in this field of research was mentioned. Most of the research in this area was done by non-psychologists. Gynaecologists have stressed the need for further research to answer the many questions that surround this operation and its sequelae. No attempt will be made to enumerate the questions but merely to discuss the areas in which the psychologist can make a contribution.

In 1890, Kraft Ebbing (quoted by Meikel et al., 1977) stressed the psychological importance of the uterus to women while Drellich and Bieber (1958) have shown that women attribute a special function to it. The importance to the woman of her potential fertility is evidenced by way of menstruation (Jeffcoate, 1957). It is postulated that the outcome of the operation in part depends on the woman's personality and her feminine experience. Women with a positive feminine self-concept will be better able to cope with the trauma of the operation without displaying any psychiatric symptoms (Wolf, 1970).

An unknown factor however is whether a particular personality type is more vulnerable than others and what factors in the personality make-up contribute to an unfavourable surgical outcome. The psychologist can provide valuable answers to these questions.

Deutsch (1942) has mentioned the fact that women employ certain mechanisms to help them allay the inner anxiety engendered by the operation. It was seen that women react differently to this operation. The psychologist can help in the understanding and clarifying of the mechanisms employed in coping with anxiety.

An area where the psychologist can make his biggest contribution is in collecting and processing of data. Many of the report findings are based on the subjective replies by women to questions. There is the inherent danger of contamination by patient compliance. Research is required to establish whether a standardised psychological test or instrument can be devised which will measure and accurately identify the necessary factors. Once the data has been collected a suitable statistical method has to be employed for its analysis.

In conjunction with the above the experimental psychologist can assist in the identification and controlling of confounding variables. It was seen that there are a multitude of factors that can have an effect on the outcome and adaptation to this operation.

An important component of an experimental approach is locating a suitable control group. The most frequently used are patients who have had a cholecystectomy. The psychologist could usefully try to establish which group of patients would be the most suitable as a control.

Controversy surrounds the most suitable follow-up period. In the reviewed studies the periods range from three months to five years. Research is needed to establish the optimum follow-up period.

Finally, the psychologist has an important role as advisor. Cohen et al. (1953) found that women with hysteria were operated on more frequently than other women. The psychologist can, after his assessment of the basic personality of the patient, advise the surgeon in the absence of any organic cause, whether further assessment is necessary before the decision to operate is made.

The implications and possibilities for future research are so many that one is left with a feeling of urgency. This is indeed unexplored territory for the psychologist.

"So much to do, so little done!  
But when its o'er - the victory won,-  
Oh! Then, my soul, this strife and sorrow  
Will end in that great, glad to-morrow."

J.R. Gilmore, Three Days.

## APPENDIX A

Throughout this dissertation reference has been made to the case histories recorded in this appendix. It was seen above that clinicians differ in their approach to hysterectomy with regard to the indications and sequelae. The adverse reactions do not occur only in a specific age group, nor is it confined to particular socio-economic status or marital status. The reactions of the women vary with no satisfactory explanation of why this should be the case.

Thought provoking assumptions about possible reasons for the reactions of women to hysterectomy have been made by psychiatrists. However, the significance of this information can only be fully evaluated following more detailed research. There are many methodological problems in this area.

### Aim

The aim is to illustrate some of the issues raised above by means of empirical case material. Structured interviews were not conducted as the object was not to make a formal psychiatric assessment but merely to record the patients subjective attitudes and reactions to the operation. All the interviews, with the exception of cases numbered 6,7,10,11 and 12 (which were done in the hospital ward) were conducted in subject's homes.

### Subjects

All the subjects were volunteers who were informed by their friends about this study. The subjects interviewed in hospital had agreed to

partake in this study after being informed of its objective. The ages of the women ranged from thirty years to fifty one years with a mean of 39,4 years. The post-operative period ranged from one week to nine years.

Apart from the fact that the subjects were all from the non-white racial group to cancel any possible cultural differences, no attempt was made to match the sample. In order to protect the identity of the subjects certain changes were made without affecting the core facts.

The case of Mrs. F. (Case No.4) who did not have a hysterectomy is included in this study to illustrate possible reasons why women may refuse to have the operation.

A summary of the cases appears in Table II.

TABLE II

SUMMARY OF CASES      P= Professional woman      H/W= Housewife

Case No.	Marital Status	Age	Reason for the Operation	Post-operative Period
1. Mrs. W	Married (P)	51	Prolapsed uterus	3 years
2. Mrs. S	" (P)	40	Dysfunctional bleeding	3 years
3. Mrs. J.	" (P)	46	Uterine fibroids and dysfunctional bleeding	1 year
4. Mrs. F.	Divorced (P)	36	Hysterectomy advised but refused	
5. Mrs. T.	Married (H/W)	45	Uterine fibroids and spontaneous abortions	1 year
6. Mrs. S.S.	" (H/W)	43	Dysfunctional bleeding	1 week
7. Miss O.H.	Single	41	Uterine fibroids and dysfunctional bleeding	1 week
8. Miss D.	"	36	Not clearly stated- possibly dysfunctional bleeding	8 months
9. Mrs. T.M.	Married (P)	39	Chronic inflammation	5 years
10. Mrs. R.	" (H/W)	30	Menorrhagia	2 years
11. Mrs. V.	" (P)	31	Chronic inflammation	6 months
12. Mrs. M.	" (H/W)	40	Dysfunctional bleeding and chronic inflammation	9 years

AREAS EXPLORED DURING THE INTERVIEWS

All the interviews were structured by informing the women that the information would be used in a dissertation. Participation was voluntary in all cases.

1. Marital status, number and ages of children.
2. The completeness of the family as seen by the woman.
3. The date and reason for the operation.
4. The amount and source of any pre-operative information received.
5. Whether the woman had had any discussion about the procedure and its effects with anyone. If she had, what information did she receive and what effect did this have on her.
6. A discussion of the woman's first reaction when she was informed that the operation was necessary.
7. The woman was asked whether her body felt any different now that the uterus had been removed. She was asked to describe this feeling.
8. Her attitude towards the fact that she was now unable to have more children.
9. The woman's attitude about the fact that she does not menstruate anymore was explored.
10. The woman was asked about any significant dreams after the operation.
11. The woman was asked what she regarded as the main function of the uterus.
12. Any feelings of depression before or after the operation were explored as well as any other changes noted e.g. menopausal symptoms.
13. All the women were given an opportunity to discuss any topic they regarded as significant. They were free to ask any questions.

The object of the interview was solely to obtain information. The word explore in this context means to gather information. At no time were any interpretations given or any attempts made to probe possible defences. The women were instructed to provide such information as they felt comfortable to discuss.

Depression was defined as the patient's subjective expression of feeling sad, or its equivalent. The word "depressed" was used by the interviewer to describe the mood state of the patient. The presence or absence of the psychiatric vegetative symptoms were not used as criteria for depression.

In none of the women were life events explored as a possible precipitating factor for the depression.

Case No. 1 Mrs. W.

Mrs. W. was a forty-five year old pre-menopausal professional woman with five children. She was married for more than twenty years when she had the hysterectomy. At the time of the interview she was in her third post-operative year. The operation was performed because of a prolapsed uterus. She had elected to have the operation for contraception and reports that she had had adequate pre-operative information.

Before the operation Mrs. W. had suffered from periods of depression. Within one year of having the operation she suffered depression and had to receive medication. The depression however was not incapacitating and she was able to perform her normal duties. She did complain of a loss of libido and attributes this to the operation.

Menstruation for her was a necessary biological function. She was not affected by the cessation of her menses. Her only pre-operative fear was that of possible death under anaesthetic.

She reports that she is completely satisfied that she had the operation.

Case No. 2      Mrs. S.

Mrs. S. was a forty year old professional woman who was married for twelve years at the time she had the operation. She has three children and was in her 3rd post-operative year at the time of the interview. The operation was done because of dysfunctional bleeding for more than a decade.

After the birth of her last child she was sterilised by tubal ligation after refusing to have a hysterectomy because of its finality. Her reason for the refusal of the operation was her desire to retain her child-bearing capacity. The dysfunctional bleeding caused so much physical discomfort that she reluctantly consented to have the operation. Mrs. S. was undecided about the completeness of her family.

Pre-operatively she was prone to periods of depression and within three months after the operation she became so depressed that she required medication. The depression was not of an incapacitating nature. She has complained of a loss of libido which she attributed to the hysterectomy.

This woman reports that she has accepted the fact that her uterus has been removed and still feels that she is a complete woman.

Case No. 3 Mrs. J.

Mrs. J. was a forty-six year old professional woman with three children. At the time of the interview she was in her first post-operative year. Her operation was done because of uterine fibroids and dysfunctional bleeding. Her discomfort with her menses was so severe that she was incapacitated for a few days every month. Before the operation her only concern was fear of death as a result of anaesthetic. She finally accepted the fact that her uterus was going to be removed.

After the operation this woman did not complain of any depression. She says she still feels a complete woman and sees the fact that she does not menstruate as a relief. There have not been any complaints of a loss of libido and no menopausal symptoms. Within two months after the operation this woman reports that everything was back to normal for her.

She reports that she is glad she had the operation.

Case No. 4 Mrs. F. (A woman who has refused to have a hysterectomy)

Mrs. F. was a thirty-six year old divorcee with one child who was advised to have a hysterectomy because of the danger of complete renal failure should she become pregnant again. This woman has refused to have the operation because she wanted to retain her child-bearing capacity.

With her first pregnancy at twenty-one years of age, she had suffered from severe pre-eclamptic toxæmia which had damaged her kidneys. She reports that while she was ill the nursing and medical staff disregarded her feelings while they discussed the possibilities of her losing her baby and whether to perform a hysterectomy or not. She says that at no time were her feelings taken into account and, "this made me switch off, I wanted to hear what they said and on the other hand I did not." She viewed her illness as some punishment from God and constantly wondered why it had to be her.

After the birth of her child she was forced to use some form of contraception because of her kidney condition. For three years she resorted to various methods of contraception with the added discomfort of metrorrhagia. Because of this she was assured by the doctors that if she discontinued the contraception she would not fall pregnant! Immediately she discontinued the medication she became pregnant, a child that she did not want. She was afraid that she or the child would die. She however went into premature labour at seven months and gave birth to a boy who died twelve hours later. This has resulted in aggressive feelings towards the medical and nursing staff of the hospital as well as tremendous guilt feelings because she says

"I did not want the child and now it is dead".

The metrorrhagia was so severe that she had collapsed because of loss of blood. She was again advised to have a hysterectomy but she kept on asking herself the question, "How will I look without a uterus?". She has suffered from severe depression and has consoled herself by saying that she may not be able to have more children but she still has her uterus. She regarded herself as still being a woman, "If I bleed, at least I'm still a woman, if I don't, what will happen?" She continued by saying, "If I have my uterus out I see myself with a beard. I am very conscious of my body, at 27 without a uterus - what kind of woman will I be - now they cannot say A... cannot have any children because she had no womb."

She has been divorced for two years now and says she is glad she did not have the hysterectomy. She says that the scar would have reminded her that she did not have a uterus. She furthermore says that she would be able to accept menopause but "I will never have my uterus out."

This woman has suffered from depression for three and a half years and has persistently refused the operation. She regards gynaecologists as incompetent, "You are just another uterus. All they say is your sex life will be OK and that is not everything."

Case No. 5 Mrs. T.

Mrs. T. was a forty-five year old housewife with no children. At the time of the interview she was in her first post-operative year. Her hysterectomy was done because of uterine fibroids and also because of multiple spontaneous abortions. She reports that when she was informed about the necessity for the operation it came as a "shock" to her because "I desperately wanted a child to make up for the ones I had lost."

This woman did not want the operation because she feared that without a uterus "My husband will throw me away because I will not be an ordinary woman." (This woman had been experiencing marital discord which could explain her pre-operative attitude). Before the operation she had been treated for depression.

Since the operation this woman reports that the frequency of intercourse has decreased. The writer tried to establish whether she had experienced a loss of libido to which she replied "I am not an ordinary woman because my husband does not want to have sex with me anymore, I feel rejected."

She has also reported that her neighbours had made derogatory remarks about the fact that she had had a hysterectomy. She further reports feelings of worthlessness which were exacerbated by her best friend having a baby. Mrs. T. further reported that this friend had told her that she was pleased not to be like the subject, that is without a uterus.

Menstruation for this woman was the evidence of her potential fertility. This has resulted in her having recurrent dreams of having profuse vaginal bleeding after the operation.

In addition to depression this woman also reported that she felt that she was growing older much more quickly now. Her friends had warned her that her strength would be less after the operation and she had found this to be true. She says "I feel like an old woman now and people look at me differently."

A further attitude this woman had about the function of the uterus was that "it is the womb that keeps a woman up" implying that the uterus gave a woman her femaleness. She reports that she does not feel a woman anymore and this was evidenced for her by the fact that the tone of her voice had lowered (the tone of her voice was in fact lower than that expected in a woman).

Case No. 6 Mrs. S.

Mrs. S. was a forty-three year old housewife with no children after being married for twenty years. She married at the age of twenty two and for twenty one years has attempted to become pregnant.

These attempts included regular visits to an infertility clinic and numerous investigations. Her husband would not avail himself of any investigation and the subject reported that he has accepted the fact that she was childless.

She was advised to have a hysterectomy because of a three year history of dysfunctional bleeding. This news made her feel sad as for her the uterus was part of the human body ("Dis deel van 'n mens"). She consented to have the operation because of the severe physical discomfort she had been suffering.

Mrs. S. was in her first post-operative week at the time of the interview and had not experienced any adverse effects up to then. She reported that she had accepted the fact that she had lost her child-bearing capacity. She saw her childless state as a punishment from God.

Because of the fact that she was childless this woman reported that for her the uterus had no function and she was glad that it had been removed. She furthermore reported that she was pleased not to be menstruating anymore because of the discomfort she had suffered.

Mrs. S. reported that that she was pleased that she had decided to have the operation because at forty-three she was, "too old now to have children."

The interviewer felt that after one week this woman had not as yet had time to integrate the fact of loss of the uterus. No further exploration was done.

Case No. 7 Miss O.H.

Miss O.H. was a forty-one year old single woman with a fourteen year old daughter. She was in her first post-operative week at the time of the interview. Her hysterectomy was done because of uterine fibroids and dysfunctional bleeding. She had suffered from this condition for one year and reports that she was disturbed when informed that the operation was necessary ("Ek het sleg gevoel").

When Miss O.H. was questioned about the significance of her uterus to her she refused to answer. She did however concede that her fear was not about the fact that her uterus would be removed but the fact of an operation and of being anaesthetised. She also reported that part of her strength would be removed with her uterus.

This woman said she was completely satisfied with the operation.

The interviewer felt that this woman was struggling with integrating the reality of the operation and of accepting her loss. Objectively she looked sad and anxious although she denied having such feelings. She was thanked for her willingness to partake in the study and the interview was concluded without further probing.

Case No. 8 Miss D.

Miss D. was a thirty-six year old single woman and was in her eighth post-operative month at the time of the interview. It was difficult to establish from her why the operation was done but the symptoms described by her were indicative of dysfunctional bleeding.

Miss D. was against having the operation as she felt she was bewitched because of an affair she was having with a man of a different religion. She was prepared to sign for any operation except a hysterectomy. It is not clear why she eventually decided to have the operation. This woman says that she did not receive any information about the operation or its effects.

Within a month after the operation she became depressed and after eight months still complained of feeling "raw inside." She also complained of menopausal symptoms, mainly hot flushes. She had not accepted the fact that she will no longer be able to have children and has expressed great sadness about it. She has consoled herself by saying that "maybe now I can be a mirror for those people who have children but do not appreciate them." She furthermore regards the operation as punishment because she was too fond of other people's children.

This woman reported that for her, the only function the uterus had was for child-bearing and since she did not have one anymore she had no interest in forming a relationship with a man. After the operation this woman had two dreams.

In the first dream she dreamt that she had given birth to a deformed

baby. She was told by friends to have the child adopted but she refused. As the child grew it became more deformed and unsightly. She continued by saying that when this child had grown up it suddenly attacked her and bit her leg from which she bled freely.

In her second dream she dreamt she was pregnant and was complaining of severe pains in her abdomen. On visiting her doctor she was told that the child was busy eating its way out of her stomach.

At the interview this woman appeared so depressed that the interviewer had suggested that she avail herself of psychiatric help.

Case No. 9 Mrs. T.M.

Mrs. T.M. was a 39 year old professional woman with three children. She was in her fifth post-operative year at the time of the interview. Her hysterectomy was done because of chronic inflammation. She reported that when she was first informed about the necessity for the operation she had refused to have it done. Her reason for this refusal was the fact that she would have loved to have had another son (her youngest child was three years at the time).

She furthermore reported that her physician had advised her of the consequences of the operation and the permanency of the procedure. From a friend she heard that this "major operation" was only done to women in their fifties which made her wonder why it was being performed on her at thirty-four years of age. Further information obtained from her physician according to this woman was that she would not feel herself after the operation and that her sex life would be affected, there would be a loss of libido!

Before the operation this woman was prone to suffer from depression. The interviewer did not enquire into precipitating events, related to her depression. She reported that within one month

of having had the operation she again suffered from depression.

She also reported that she repeatedly dreamt that she was pregnant and how happy she was at having conceived.

She reports that waking and being faced with reality made her very depressed. She has also dreamt of profuse vaginal bleeding and on waking would expect to find the bedding soiled. She again reports that it made her feel depressed to realise that she would not bleed again. It is interesting to note that this woman has

reported that menstruation did not have any special significance for her.

Mrs. T.M. further told the interviewer that the relationship between her and her husband had changed. She perceived him as unsympathetic and non-caring. There would be arguments about sex. She says she would like to please him but suffers from a loss of libido.

This loss she attributes directly to the operation. She also reports that she does not feel happy within herself, she says she feels "leeg" (empty) inside. The loss of the child-bearing capacity has not been accepted by her. After five years she still regrets her decision to have the operation.

Her oldest son who was fifteen years at the time of the interview had contracted an incurable disease. This has increased her desire for a replacement child. She requested of the interviewer whether a reversal of the effects of the hysterectomy was possible! She reported that for her a child had a significance she could not explain.

She conceded that physically she was much healthier but her marriage was ruined. She had also lost some of her strength as she felt she was now able to do less physical work than before the operation.

Case No. 10 Mrs. R.

Mrs. R. was a 30 year old housewife with four children and was in her second post-operative year at the time of the interview. Her hysterectomy was performed because of menorrhagia. She was admitted to a psychiatric hospital after having taken an overdose of tablets in an attempt to commit suicide.

This woman dated the onset of her depression to the time she had her hysterectomy. She reported that she became progressively more depressed over the two years following the operation. She had become more irritable, suffered from insomnia and generally felt that she could not cope with the demands of the day.

Mrs. R. did not suffer from depression before the operation and described herself as a cheerful outgoing person. She furthermore reports that before the operation she had received adequate information and was willing to have the operation. There was no loss of libido post-operatively.

This woman was reluctant to talk about the attitudes about the function of the uterus and the significance of menstruation. She did however talk freely of her early life.

Her mother died when she was seven years of age and her father when she was eighteen years. At fifteen years she had an appendectomy. She describes her childhood as very unhappy and when her mother died her father moved out of the house leaving the subject and her two

siblings, (one older and one younger than herself) in the care of her aunt. The children moved from one aunt to another and the subject describes this period as "the most unhappy time of my life."

She reported that she had her first sexual experience at 17 years with the man she subsequently married.

Mrs. R. furthermore reports that her husband has supported her throughout the two years that she was depressed. The only effect she reports to have suffered was depression.

Case No. 11 Mrs. V.

Mrs. V. was a thirty-one year old professional woman who was in her sixth post-operative month at the time of the interview. The operation was performed because of chronic inflammation, three years after having been sterilised.

This woman who comes from a country town was admitted to a psychiatric hospital because of severe depression six months after her hysterectomy. She reports that her physician had given her full pre-operative information about the operation and its effects and that she consented for health reasons. She reported that the sterilisation was done three years prior to the hysterectomy and says that it was performed without her knowledge or consent! The subject's mother had died one year prior to her having the operation. She reported that she had had a very good relationship with her.

Three months after the operation during the month of the first anniversary of her mother's death Mrs. V. complained of severe anxiety attacks accompanied by depression. She reported that she felt sad at the fact that her uterus had been removed and complained of a loss of strength and energy. She furthermore complained of a loss of libido which she attributed directly to the operation.

This woman's depression was so severe that she had to be hospitalised for six weeks. She has denied any previous attacks of depression. At the time when her symptoms first appeared, Mrs. V. who is a teacher was asked to teach music. She reported that she had no knowledge of music and felt that she was unable to perform this task. This exacerbated her anxiety and depression and it was poor work

performance that precipitated her admission to hospital.

At the time of her discharge her depression had lifted but she still had signs of anxiety.

Case No. 12 Mrs. M.

Mrs. M. was a forty year old housewife with six children. At the time of the interview she was in her ninth post-operative year. Her hysterectomy was done because of dysfunctional bleeding and chronic inflammation.

This woman did not want to have the operation but had consented for health reasons and after 9 years she still regrets having had the hysterectomy. She furthermore reported that she had received a limited amount of information pre-operatively.

When this woman was interviewed she had been re-admitted because of severe anxiety and depression. She described a life of general inability to cope with life's stresses. Her childhood was described by her as having been very unhappy. She attributed this unhappy situation to her father drinking and his resultant aggressive behaviour when under the influence of alcohol.

When she was five years old she was severely burnt by fire on the right side of her body. She had to be hospitalised for one year receiving several skin grafts. Scar tissue formation had prevented her right breast from developing. This has been a source of embarrassment to her and she does not undress in front of people and never went to the beach because of her poor body image and teasing by peers.

She furthermore reported that in order to escape from what she described as an intolerable home situation she married a man nine years her senior when she was eighteen years of age. Six children were born

of this marriage.

Her general inability to cope has resulted in this woman suffering from depression before the operation. Her children became delinquent and she had great difficulty coping. Within one month after the operation she again became depressed and over the past nine years has had frequent depressive episodes. She reports that she feels "leeg" (empty) inside and that "alles is uitgehaal" (everything has been removed). Her regret at having had the operation is at its worst when her two teenage daughters menstruate, this makes her feel that she is only half a woman.

Just before her admission to hospital two of her sons were committed to a school of industries. This made her feel that she had failed as a mother.

OVERVIEW

The sample size was considered too small for generalisation. The recorded cases do however illustrate some of the issues raised in the literature, the most notable being the wide range of reactions of women to this operation.

The women's reactions recorded in cases numbered one to three could be considered as favourable. They reported little or no ill effects and were pleased that they had had the operation.

Drellich and Bieber (1958) reported that women still attributed some special function to the uterus. Mrs. F. (Case No. 4) has refused to have a hysterectomy because for her the uterus is synonymous with her femininity.

There are authors who report fairly severe effects following this operation (Richards, 1973; Richards, 1974; Barker, 1968; Barglow et al., 1965) with the most incapacitating symptom being that of depression. In three of the women interviewed, Mrs. R., Mrs. V., and Mrs. M. (Cases numbered 10, 11 and 12) their post-operative depression was so severe that they had to be hospitalised.

Chynoweth and Abrahams (1977) have emphasised the importance of life events as a possible contributory factor to the depression with which the woman presents. In none of the recorded cases however were specific questions asked about life-events and so the conclusions have to be evaluated with this omission in mind for example, depression and anxiety with which Mrs. M. (Case No. 12) presented could have been as the

result of life-events unrelated to or in addition to the stress of hysterectomy. It would however be difficult to explain why after nine years this woman complains of feeling "leeg" (empty) inside if only unrelated life events were responsible for her depression.

The contribution made by Deutsch (1942) about possible psychoanalytical explanations for the reactions of women is thought-provoking and merits further research. Mrs. I.M. (Case No. 9) reported that for her a child had a significance she could not explain. Mrs. V's symptoms appeared three months after the operation during the month of the anniversary of her mother's death (Case No. 11).

Many possible explanations could be offered why the women recorded in this appendix became depressed. At the same time it cannot be denied that some of the subjects were very definite in their attitudes toward the operation.

## APPENDIX B

It was seen in Chapter 6 that one of the most popular methods of research into the effects of hysterectomies is by means of the questionnaire method. This is also one of the methods used in retrospective studies. One of the problems created by this method of data collection is the absence of some baseline pre-operative information. There is also the possibility of patient compliance and much of the information not being committed to paper. It is doubtful whether information about such an intimate and personal event can be elicited by the questionnaire method.

### Aim

The aim of this part of the study is to illustrate that when used alone the questionnaire method of data collection is insufficient. It was decided to investigate women's attitudes to menstruation because of the very personal nature of this event and of its direct relationship to hysterectomies.

One of the underlying assumptions was that when the questionnaire is used alone important information will be omitted by the subject. Furthermore the woman will not include any details that are of a personal and intimate nature in their answers.

### Subjects

The women were chosen randomly, and, after an explanation of how the information will be used in this study they all willingly completed the questionnaire. Sixteen women were included with ages ranging from fifteen to forty four years (mean age 26,1 years). Married and single women were included.

QUESTIONNAIRE

1. How old were you when you started menstruating?
2. Were you prepared for the event?
3. How did you feel/react to your first period?
4. Are you regular?
5. Have you any children?
6. If married, do you consider your family complete?
7. Do you look forward to your monthly period?
8. How would you react if for some medical reason your periods stopped?
9. How would you feel if your periods stopped for no medical reason?
10. Does your period have any special significance to you?
11. If you have a choice would you elect to stop your periods or not and why?

ANSWERS TO QUESTIONSCase No. 1Miss A. Age: 17 years

1. 13 years
2. No
3. Shy
4. No
5. No
6. Not applicable
7. No
8. I will be worried
9. If I had sex, I will be scared but otherwise I won't worry
10. No.
11. No - It lets me feel a "pure woman"

Case No.2Miss B. Age: 30 years

1. 14 years
2. No
3. I was shy and did not know how to tell the family
4. No
5. Yes
6. Not applicable
7. No
8. I will be worried, but will follow medical advise
9. If I had no sex I will wait for 2 to 3 months then see my doctor.
10. No
11. Yes - because I feel very uncomfortable before and during my period.

Case No. 3Miss C. Age: 15 years

1. 12 years
2. No
3. I was shocked, I wanted to cry
4. Yes
5. No
6. Not applicable
7. Never
8. I will definitely be worried
9. Scared stiff
10. Yes. To me this is the first step to becoming a woman.
11. No. Despite the unpleasantness I will not feel a complete young lady.

Case No. 4Miss D. Age: 30 years

1. 11 years
2. More or less
3. Not very pleased
4. In the beginning, but not regular now
5. No
6. Not applicable
7. No, but I have to accept it
8. I will consult a doctor and seek medical advice
9. Not pleased because I am sure the full feeling before menstruation will still be there.
10. No
11. No.

Case No. 5Miss E. Age: 26 years

1. 12 years and 6 months
2. No
3. Embarrassed because I was camping with an elderly couple
4. Yes
5. No
6. Not applicable
7. Not really
8. I will worry and see a doctor as soon as possible
9. Scared stiff, I'll possibly know why
10. Yes, it shows that I am functioning fully
11. No, only if there is a replacement, I feel that menstruation signifies womanhood and the onset of pregnancy.

Case No. 6Mrs. F. Age: 28 years

1. 13 years
2. Oh, yes
3. I was frustrated, I could not be active
4. Yes
5. Three children
6. Yes
7. Never
8. Okay
9. Very worried
10. Yes, it makes me feel I am a woman
11. No, after all that's my womanhood

Case No. 7Mrs G. Age: 44 years

1. 14 years
2. No
3. I was shocked
4. Not always
5. Yes, 4
6. Yes
7. Yes
8. Frightened
9. My first reaction will be "What's wrong with me?"
10. Having periods is part of being a woman
11. No, its a natural cause

Case. No. 8Miss. H. Age:18 years

1. 13 years
2. No
3. Shy
4. Yes
5. No
6. Not applicable
7. Yes
8. Worry
9. Afraid
10. No
11. No

Case No. 9Mrs. I    Age: 27 years

1. 13 years
2. No
3. Afraid of telling my mother
4. No
5. Yes - 2
6. Yes
7. No
8. Accept it
9. A bit anxious at first
10. No, its part of my biological development
11. No - as it causes no problems but is part of my physiology

Case No. 10Miss J.    Age: 25 years

1. 13 years
2. No
3. I cried and thought I was dying
4. No
5. No
6. Not applicable
7. Yes
8. Worried until the medical condition is cleared up for the period to return
9. Worried
10. Yes, it makes me believe that I might be able to bear children
11. No. Despite the discomfort, I feel it is all part of being a total woman

Case No. 11Miss K. Age: 29 years

1. 13 years
2. Vaguely prepared - sexual information from books/friends. Sex was not spoken about at home.
3. Very astonished, I was worried and immediately told my mother who was very pleased and informed the whole family. I was slightly embarrassed.
4. Yes, very regular
5. No children
6. Not applicable
7. At this stage I have accepted my periods as a normal biological function which in my earlier years proved to be troublesome
8. I would be worried and anxious - for me my regular period means sound health
9. If it stopped for no medical reason I would suspect something psychological - I will seek professional help
10. Yes - its an integral part of my femininity and my womanhood
11. I can see no reason why I should want to stop my periods since it is a very necessary biological function

Case No. 12Mrs. L. Age: 27 years

1. 11 years
2. No
3. Did not know what was happening
4. Yes
5. Yes
6. No
7. Not really
8. I would like to know the reason why
9. Would be concerned

Case No 12 Cont.

10. No

11. Yes - so that I could feel free of an uncomfortable feeling

Additional information obtained on enquiry:

Mrs. L. had an older sister whom her mother thought would menstruate before her with the result that her sister was prepared and not her. She was under the impression that menstruation was only something married women experienced. For the first two days she did not know what was happening and did not tell anyone because she was embarrassed (Questions 1 to 3).

She has regular periods but does not look forward to them because of the physical discomfort. She regards it as a nuisance because of constant care she had to take against soiling her clothes. She feels that during her periods she cannot partake in all the activities she would like to (Questions 6 and 7).

She would like a detailed explanation from a doctor as to the cause and the prognosis of the medical condition. She will accept the stopping of it heralded the commencement of menopause (Questions 8 to 9).

She would elect to stop her menstruation because of the physical discomfort on the condition that she could have the guarantee that she would still be fertile! For her the monthly cycle is an indication of her fertility (Questions 10 to 11).

Case No. 13

Mrs. M.    Age: 34

1. 11 years
2. No
3. I informed my mother who spoke to me and I continued to play
4. Yes
5. Yes
6. No
7. Yes
8. I will accept it if I know what the reason is
9. I will be concerned, incomplete
10. Just that I'm OK
11. No, because I would not be myself without

Additional information obtained on enquiry:

Mrs. M. comes from a family where sexual matters were fully discussed. She had been informed about menstruation by her mother and older sisters. There was no embarrassment on her part at her menarche. (Questions 1 to 6). She looks forward to her periods because for her it is a signal of good health. Her regular monthly cycle makes her feel like a normal woman with her physiology functioning satisfactorily. It is also a sign that she is potentially fertile and not pregnant (Question 7). If her menstruation stopped for any reason she would immediately suspect that there was something wrong with her bodily functions. For her, regularity of the menses is a biological clock indicating good health - she regards it as one of her systems of her body like the respiratory system. Without her menses she would feel an incomplete woman, I will be "a half woman". It i.e. menstruation is part of a private "make-up" and entitles her to feminine privileges (Question 9). She would not elect to stop her periods as this would herald

some physical change.

Case No. 14

Mrs. N. Age: 28 years

1. 12 years
2. No
3. Scared - did not know what it was. Consulted mother who informed me what it was and the problems it could cause.
4. Yes
5. Yes
6. No
7. No
8. Normal
9. Worried
10. Yes
11. No because it is natural

Additional information on enquiry:

Her mother did not inform her before about menstruation but when she started she was given some information. The problems her mother warned her about was the possibility of pregnancy because she was now fertile (Questions 2 and 3). Because she is regular she normally calculates with some accuracy when she is due. This removes for her the element of expectancy (Question 7).

She reported that she would not be unduly concerned if her periods stopped because as a professional woman, she would seek advice and have any possible problem investigated. If there was no medical reason for the stoppage she would simply think she was pregnant (Questions 8 and 9).

For her, menstruation relates strongly with her feelings of femininity. One of the roles of being a woman is to conceive and menstruation is a sign of potential fertility and of good health (Questions 10 and 11).

Case No. 15

Miss O. Age: Early 20's

1. 12 years
2. Yes
3. (unanswered)
4. Yes
5. No
6. Not applicable
7. Yes
8. Pleased
9. Yes
10. Yes
11. Yes

Additional information on enquiry:

Because of the contradictory answers to questions 7,8 and 9 this woman was asked to elaborate. This enquiry developed into a therapeutic session and because of the confidentiality of the information and at her request only the main parts are mentioned below:

1. There is a history of hysterectomies in her family and all the women had problems with their menstruation.
2. When she menstruates she becomes very ill and is on medication to combat this.
3. Her ambivalence was explained as partly her fear of a possible hysterectomy because of her difficulties with menstruation and the family history.

Case No. 15 Cont.

4. She has a very strong desire to bear children.
5. Menstruation for her is a sign of her potential fertility.

Case No. 16

Miss P.    Age: 18 years

1. 13 years
2. Yes
3. Shy and lady like
4. Yes
5. No
6. Not applicable
7. No
8. Be happy
9. Very worried
10. Yes
11. Yes. Then I would not get so sick when I get my period

Additional information on enquiry:

At first glance the answers of this woman are no different to those of the other women of the sample. She was a patient in a psychiatric hospital when the questionnaire was given to her because of severe psychiatric disturbance related to her menses. A brief summary of her illness is given below.

History of presenting illness

The patient's illness dates back to 1979, prior to which time she was perfectly well. At this time, the patient was 16 years old and developed an illness related to her menses. She was admitted to hospital and fully investigated. She has had 9 subsequent similar episodes, all

Case No. 16 Cont.

related to her menses, and is well in the period in between. A typical attack is as follows:

A day or two prior to menstruation, the patient becomes constipated and nauseous. At menstruation, she develops intense abdominal pain, which is mainly epigastric, vomits copiously wherever she is and her behaviour takes on a bizarre form.

She flings herself around, screams, clings to medical personnel begging for help and protection and covers herself in menstrual blood.

She does not eat anything during the period of her menses. On receiving an injection of a minor tranquiliser she quietens down, but the picture reappears when the drug begins to lose effect. The episode ends with the cessation of her menses.

During these attacks she has been hospitalised twice and has attended psychiatric casualty on many occasions and has spent a short period as an in-patient. She was admitted to the psychiatric hospital in May 1981 during an attack, for a full assessment of her problem.

## DISCUSSION

The answers of 16 women to 11 questions about their attitudes to menstruation was presented. The answers can be divided into three sections, (a) case nos. 1 to 10, (b) case no. 11 and (c) case nos. 12 to 16.

In the first section the answers were accepted as they were received with no enquiry. It is noted that most of the answers are monosyllabic with no indication of the motivation behind the answer. Five of the 10 women answered that for them menstruation did not have any special significance. Because no definition was given of what the investigator meant by "significant" it can only be concluded that each woman had formulated her own definition. To question 11, 9 women elected not to stop menstruating for various reasons. The general theme of the reasons was that menstruation was related to feelings of femininity.

From section (a) it is clear that unless the meaning of each question is explicitly formulated with specific definitions each reader will interpret the question to comply with her own frame of reference. This is of particular relevance to South Africa's multi-racial situation when a cross-cultural study is contemplated. It is possible that attitudes and meanings will differ from culture to culture.

### Section (b)

This answer can be regarded as an exception to the rule. Her answers are in greater detail than the other women. A possible reason for this could be the fact that Miss K. was a professional woman familiar with research methods. This deduction can be made from her answer

to question 10 that she has formulated what for her is feminine and what relates to being a woman. The examiner in the absence of a follow-up enquiry has no idea what this woman meant by these terms.

### Section (c)

In this section a very short follow-up interview was held with the women numbered cases 12 to 16. The examiner was able to obtain detailed information about various answers recorded. Of particular interest are answers of cases 15 and 16; Miss O. (Case No. 15) was a woman with very strong feelings about menstruation and the particular fear it had engendered in her. There was no means for her to commit this to paper and was only able to do so in an unstructured interview. A similar situation was encountered with Miss P. (Case No. 16). Her reaction to her menses had resulted in such an emotional disturbance that she was admitted to a psychiatric hospital. Her answer to question 11 gives no indication that she has such serious problems with her periods.

### Conclusion

In the sample of sixteen women it was seen that in the absence of clearly delineated definitions the women attributed their own meanings to the questions. A comparison of the answers in the three sections and the additional information obtained in section (c) is evidence that additional information is obtained when the questionnaire is used together with an informed interview.

The value of the questionnaire method lies in the uniformity of the areas covered. This will facilitate the analysis of the data collected. It was seen from Chapter 6 that a suitable measuring

instrument is needed to measure the subjective answers this method of research has dealt with.

GLOSSARYAMENORRHOEA

the absence of the menstrual flow during the time of life at which it should occur

ANAEMIA

Deficiency in either quality or quantity of red corpuscles in the blood

APPENDECTOMY

(or appendicetomy), is the operation for the removal of the appendix vermiformis

BROAD LIGAMENT

folds of peritoneum extending from the uterus to the sides of the pelvis, and supporting the blood vessels to the uterus and Fallopian tubes.

CARCINOMA

is another name for cancer

CELLULAR TISSUE

is an old name for the loose fibrous tissue which forms, so to speak, packing between the skin and muscles and round the different organs.

CERVIX

the neck of the uterus and is placed partly above and partly within the vagina.

DYSFUNCTIONAL BLEEDING

abnormal uterine bleeding in the absence of any kind of pregnancy, any variety of inflammation and benign or malignant neoplasm

HYSTERIA

a psychoneurosis manifesting itself in various disorders of the mind and body. There are mental and physical symptoms, not of organic origin, produced and maintained by motives of which the patient is unconscious, but directed at some real or fancied gain to be derived from them.

HYSTERECTOMY

an operation for the removal of the uterus

ILIAC VESSELS

these are blood vessels. The aorta ends in the two common iliac vessels each of which divides into the internal iliac to the organs in the pelvis and the external iliac to the lower limb.

LYMPH NODE

Lymph is the fluid from the blood which has transuded through capillary walls to supply nutriment to tissue cells. The nodes or glands are structures placed along the course of the lymph vessels through which the lymph passes and is filtered of foreign substances, e.g. bacteria

METRORRHAGIAMENORRHAGIA

excessive menstruation, the former if the flow is at irregular periods and the latter at regular periods

MENOPAUSE

the term applied to the cessation of menstruation at the end of reproductive life. Usually it occurs between the ages of 45 and 50 years

MENSTRUATION

a monthly discharge of sanguineous fluid from the uterus, commencing at the age of puberty and lasting until the menopause.

NEOPLASM

means literally a "new formation", is another word for tumour

NEPHROTIC SYNDROME

a term applied to a class of disease of the kidneys

OVARIES

these are glands in which are produced, in the female sex, the ova, capable if fertilised, of developing into new individuals

OVARIOTOMY

the operation of removal of an ovary or an ovarian tumour

PRE- ECLAMPTICTOXAEMIA. (P.E.T.)

toxaemia is poisoning of the blood by the absorption of toxins. Eclampsia are fits which may occur in untreated cases of toxaemia of pregnancy. P.E.T. is characterised by albumin in the urine, hypertension and oedema - if untreated there is the possibility of eclampsia developing

PARITY

the condition or fact of having borne children

TONSILLECTOMY

excision of one or both tonsils

TUBAL LIGATION

the application of a thread of silk, cat-gut or other material used for tying the fallopian tubes as a method of sterilisation accompanied by cutting the tube between the ligatures and embedding the ends on the broad ligament tissues.

From Blacks Medical Dictionary

William A.R. Johnson

13th Edition, London.

Adam and Charles Black 1974.

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