

# Depression And Anxiety In Patients Undergoing Hysterectomy

Yasmin N. Farooqi

## ABSTRACT

**Objectives:** The present research evaluated depression and anxiety in patients undergoing hysterectomy during their pre-surgical and post surgical phases.

**Design:** A Pre-Post Research Design was used.

**Place and duration of study:** This study has carried out at Department of Gynaecology Lady Wellington Hospital Lahore Pakistan

**Subjects & Methods:** Sample consisted of 50 hysterectomy patients, selected from the Gynaecology Department of Lady Wellington Hospital of Lahore, Pakistan. Each subject was individually administered Depression Scale and Anxiety Check-List twice; that is: 1-7 days before and 1-7 days after surgery.

**Results:** All the hysterectomy patients seemed to experience more depression ( $t=2.55; df=48; *p<0.05$ ) and anxiety ( $t= -5.74; df=48; *p<0.05$ ) during their post-surgical phase as compared to their pre-surgical phase, probably due to the psychosocial and cultural misconceptions and biased attitudes attached to “loss of uterus” in Pakistani society where a woman’s status and role primarily revolves around her reproductive capacity.

**Key words:** Hysterectomy, Anxiety, Depression

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## INTRODUCTION

The loss of the uterus via hysterectomy carries significant negative repercussions especially in the case of women from developing countries. As this surgical procedure results in the loss of reproductive capacity it is avoided in younger women even at the cost of their lives<sup>1</sup>. Even for women who do not wish to have more children the uterus is not an organ to be discarded lightly. The very knowledge that she is ‘normal’ and the recurrent evidence of this by way of menstruation, are psychologically if not physically important.<sup>2</sup> The side effects of this surgical treatment invariably cause some loss of function such as cessation of menstruation, infertility and hormonal imbalance. These changes may in turn influence sexual functioning. Patients may also experience general feelings of malaise which are threatening to females especially, in a traditional society where females are supposed to live within the four walls of their houses and bear children. Jochimsen (as cited in Branolte-Bos, 1991) found that 82% of hysterectomy patients reported a poor body-image which may be attributed to the importance attached to this organ. The socialization process instils the value of the uterus and its functions and of the body as a whole which may lead to perceptions of poor body image and inadequacy<sup>3</sup>.

Many women are surprised to find that after they have undergone hysterectomy they feel ‘spoiled’ and less valuable<sup>4</sup>. Hysterectomy has traditionally been regarded as having an adverse effect on women’s sexuality because it is thought to reduce their sense of femininity<sup>5</sup>. Women are referred to psychiatrists much more commonly after hysterectomy than after any other operation<sup>2</sup>. According to Roeske<sup>6</sup> the most frequent psychopathological reaction is depression as a mourning process occurs as a woman reintegrates her gender identity after the operation. Pakistan is a country with a birth rate of 3.1%, the highest in the world. Mainly parents, especially the father, desire a large family and, in particular a large number of sons in Pakistan<sup>7</sup>.

A woman who is unable to produce children is viewed as being incomplete and is assigned a low status within the family as well as society. This may cause the woman to reassess the meaning and purpose of her marriage<sup>8</sup>. Loss of the ability to bear children may also result in increasing family pressures and at times divorce or re-marriage of the husband.

The reactions experienced by women undergoing hysterectomy are similar to those of bereavement; that is: an initial phase of disbelief that it has been removed, followed by sadness and depression<sup>9</sup>.

Baum<sup>10</sup> suggests that surgical procedures like hysterectomy are emotionally stressful and may lead to depression and anxiety in females undergoing this procedure. The removal or alteration of body parts, which are symbolically significant for traditional femininity, may cause major emotional repercussions to the females whose femininity and role-identity seems to be threatened by such procedures. The uterus contributes to a woman’s sexual, reproductive and social identity. They are

related to the concepts of femininity, sexuality, procreation and motherhood and are necessary parts of a woman's body-image<sup>1</sup>. The present research is an attempt to investigate depression and anxiety as experienced by patients undergoing hysterectomy during their pre-surgical and post surgical phases.

## **SUBJECTS AND METHODS**

The sample consisted of 50 hysterectomy cases. All the hysterectomy cases (n=50) were selected from the Gynaecology Department of Lady Wellington Hospital of Lahore, Pakistan. The researcher selected only those patients in this research project, whose age was between 30 to 60 years and agreed to participate and who had been married for 10 or more years, with at least one child.

**Instruments:** Depression Scale, Anxiety Check-List and Personal History Questionnaire were constructed. The rationale for the Depression Scale was derived from DSM IV (1994) and Beck<sup>11</sup>. Depression Inventory(1993). It measured the severity of depression in each patient during their pre and post surgical phases and consisted of 19 items. The rationale for the Anxiety Check-List was derived from DSM IV (1994) and Taylor<sup>12</sup> Manifest Anxiety Scale (1951) and consisted of 55 items. Items pertaining to physical, psychological and social symptoms experienced during this stressful period were included in the Scale and Check-List. Each item was scored on a three-point scale ranging from 0-2. A score of 0 indicated absence of the symptom. A score of 1 indicated occurrence of the symptom with mild severity. A score of 2 indicated occurrence of the symptom with greatest severity. After obtaining informed consent from the patients and assuring them of confidentiality, the researcher first administered the Personal History Questionnaire to collect demographic information from the patients. The Anxiety Check-List and Depression Scale were individually administered by the researcher. Each patient was evaluated on Depression Scale and Anxiety Check-List twice: The pre-surgical phase (1-7 days prior to surgery) and post surgical phase (1-7 days after surgery).

## **RESULTS**

The mean age of the sample (hysterectomy patients) was 42.4 years. The level of Education ranged from 1-16 grades. 64% of the sample was uneducated, 16% were between grade 1 to 10, and 20% between grade 11 to 14. 36% of the sample were working and 64% were non-working women. 8% of the sample had 1-2 number of children; 45% had 3-4; 27% had 5-6 and 8% had 7-10 ( Table 1).

Pre and Post Surgical Depression scores of Hysterectomy Patients on the Depression Scale are shown in Table 2. It shows that there is significant difference in depression ( $t= -2.55; df=48; *p<0.05$ ) of hysterectomy patients during the pre surgical and post surgical phases. It can be observed that greater depression is manifested in the post surgical phase by patients undergoing hysterectomy ( $M=12.48$ ) as compared to their pre-surgical phase ( $M=10.44$ ). Pre and post Surgical Scores of Hysterectomy Patients on Anxiety Check List shown in Table 3.  $t$  These findings ( $t= -5.74; df=48; *p<0.05$ ) also indicate significant difference in anxiety in hysterectomy patients during the pre surgical and post surgical phases. The current results indicate that pre-surgical anxiety ( $M=13.38$ ) is low as compared to post surgical anxiety ( $M=27.10$ )

## **DISCUSSION**

According to Lipowski<sup>5</sup> anatomical loss of body parts which have a symbolic significance are a crucial factor in determining emotional response. As the uterus is a highly valued body part, its loss carries physical and emotional repercussions and may result in intense psychological reactions across the globe. It can be argued that in Third World countries like Pakistan, great importance is attached to the females' capacity to bear children because in such traditional societies females are "perceived" as "reproduction machines." Patients who have undergone hysterectomy have to come to terms with their incapacity to bear children, which can threaten their self-worth<sup>13</sup>. Roeske<sup>6</sup> (1978) suggest that high levels of depression are observed before and after surgery.

13. Current research findings ( $t= -5.74; df=48; *p<0.05$ ) also indicate significant difference in anxiety in hysterectomy patients during the pre surgical and post surgical phases. The current results indicate that pre-surgical anxiety ( $M=13.38$ ) is low as compared to post surgical anxiety ( $M=27.10$ ) (See Table 3). According to Wilson-Barnett<sup>14</sup> medical procedures evoke anxiety and discomfort and many patients remain inadequately prepared to face this experience. This significant difference indicates that anxiety does not decrease post operatively and is a common reaction to the fear of the

**Table 1: Descriptive Characteristics of the Sample (n=50)**

Variables	Hysterectomy Cases n =50	
	Frequency	Percentage
<b>Subject's Age:</b>		
30-39 (years)	14	28%
40-49	30	60%
50-59	5	10%
60-	1	2%
<b>Level of Education:</b>		
Illiterate	32	64%
Grade 1-10	8	16%
Grade 11-14	10	20%
Grade 15-16	0	-
<b>Occupation :</b>		
Working	18	36%
Non-working	32	64%
<b>Marital Status:</b>		
Married	50	100%
<b>Duration of marriage:</b>		
10-15 (years)	7	14%
16-20	12	24%
21-25	14	28%
26-30	15	30%
31-35	1	2%
36-40	1	2%
41-45		
<b>Total Monthly Income:</b>		
1,000 - 1,499	-	
1,500 - 6,499	10	20%
6,500 - 11, 499	22	44%
11,500 – 16,499	5	10%
16,500 – 21,499	13	26%
21,500 – 26,499	-	
26,500 – 31, 499	-	
<b>No. of Children:</b>		
1-2	4	8%
3-4	23	45%
5-6	19	27%
7-8	1	2%
9-10	3	6%

Note: Percentage of each sub-classification is based upon the total number of subjects in the group: hysterectomy cases (n=50).

**Table 2: Pre & post Depression Scores of hysterectomy patients on the Depression Scale**

Depression Scores	<u>N</u>	<u>M</u>	<u>SD</u>
Pre-Surgical Scores	50	10.44	4.31
Post-Surgical Scores	50	12.48	3.71

SE = 0.80 -2.55; df=48; p<0.05

**Table 3: Pre & post Anxiety Scores of hysterectomy patients on Anxiety Check-List**

Anxiety Scores	<u>N</u>	<u>M</u>	<u>SD</u>
Pre-Surgical Scores	50	13.38	10.86
Post-Surgical Scores	50	27.10	13.00

SE = 2.39- 5.74; df=48; p<0.05

N.B: Pre-Surgical Scores refer to subjects' scores on Depression Scale or Anxiety Check-List 1-7 days prior to surgery and Post-Surgical Scores are 1-7 days after surgery.

unknown. It may be argued that in a society like Pakistan women are viewed as “breeding machines” due to which loss of an organ vital to femininity, inability to fulfil the “role identity” demanded by the prevailing culture, incapacity to bear children and physiological changes accompanying the surgery might cause post-operative anxiety to increase. Moreover, there is no concept of couple therapy or sex-education in Pakistani society which could help the patient grapple with her fears and misconceptions about her sexual role and function after hysterectomy.

The period before surgery appears to be of maximum stress for most women and counselling particularly before and after surgery may help to lessen apprehensions<sup>15</sup>. Due to lack of emphasis on psychotherapeutic interventions and rehabilitation programs many patients may overlook the psychological aspect associated with their surgery. The professionals too are too busy and even tight-lipped about these crucially important areas pertaining to the rehabilitation of hysterectomy patients. Intolerance for psychological diseases may also inhibit females from expressing their true feelings. Counselling, rehabilitation and psychotherapy may help in relieving psychological stress felt by the family and depression and anxiety in the patient. The effect of surgery on the female self-concept and role of social support<sup>16</sup> in recovery are related. Low levels of support from family and spouse indicate poorer outcome.

In Pakistani society, females are occupied with fulfilling the multifarious roles assigned to them by society. Due to this their health suffers which is compounded by a blatant disregard for their welfare, even in their hour of need such as recovering/recuperation from major surgery. It is suggested that sharing of apprehensions by the patient with their families may serve to reduce the patient’s anxiety and depression and assist her recovery. Thus, better treatment and case management strategies can be introduced to alleviate the sufferings of the hysterectomy cases in Pakistan.

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