Gynecology & Obstetrics

Mehra, Gynecol Obstet (Sunnyvale) 2014, 4:12
http://dx.doi.org/10.4172/2161-0932.1000255

Review Article Open Access

Hysterectomy-"Anger against the Womb" A Psychological Perspective. Implications for Services

Anu Mehra*

Centre of Excellence, Great Lever Health Centre, UK

***Corresponding author**: Anu Mehra, NHS Bolton CCG, Greater Manchester, Lancashire, UK, Tel: 00441204462141; E-mail: anu.mehra2011@nhs.net

Rec date: Nov 07, 2014; **Acc date:** Dec 12, 2014; **Pub date:** Dec 14, 2014

Abstract

Hysterectomy is one of the commonest gynecological surgeries removing a "valued object" which could be related to pain- both physical and psychological, and depression. Pain, anger and depression are psychologically related.

It is also known that women who have a hysterectomy suffer far worse psychological and physical symptoms of menopause as compared to women who have a natural menopause. This study aimed to look at the relationship between anger and depression as psychological correlates and see if women who had had a hysterectomy could be suffering from the same. The morbidity associated with hysterectomy in terms of both physical and psychological symptoms is quite significant and worth looking at the burden this puts on service provision and has implications for commissioning of services that these women need and where are they best placed; Secondary care with gynecologists or psychiatrists/psychologists/therapist, or Primary care with GP's or through the Internet. Anger can be described as a natural automatic response to pain which is experienced as unpleasant and which can be physical or emotional. Anger is elicited when a person feels threatened or rejected and it can be a substitute emotion so the person does not feel pain. This happens consciously or unconsciously. Bodily aches and pains are common in Depression and these symptoms are also associated with Menopause- natural or induced. Should a psychiatric assessment prior to hysterectomy with identification of anger, and pain issues be made a pre- requisite before this surgery is offered.

These women need on-going treatment and support with menopausal symptoms and where are these services?

Keywords: Gynecological surgeries; Menopausal symptoms; Osteoarticular pain

Hysterectomy-Anger and Depression Psychology and Services

Hysterectomy is one of the commonest gynecological surgeries removing a "valued object" which could be related to pain- both physical and psychological, and depression. Pain, anger and depression are psychologically related.

It is also known that women who have a hysterectomy suffer far worse psychological and physical symptoms of menopause as compared to women who have a natural menopause. The morbidity associated with hysterectomy in terms of both physical and psychological symptoms is quite significant and worth looking at the burden this puts on service provision and has implications for commissioning of services that these women need and where are they best placed; Secondary care with gynecologists or psychiatrists/ psychologists/ therapist, or Primary care with GP's or through the Internet.

The Menstrual period has been described as tears of blood shed by the woman's womb at the bereavement or loss felt at the ovum not being fertilized by the sperm to create an embryo. Creation of life, and its related sexuality, femininity are the domain of the woman. Hysterectomy is removal of the womb with all these related functions that it serves. It is one of the commonest gynecological surgeries performed across the world with an estimated 1 per minute in the US.

Common indications include; Fibroids, Heavy menstrual bleeding, Endometriosis and Malignancy. We must agree that all these indications have pain as a predominant symptom felt by the woman. Depression has been described in Freudian terms as "depression mirrors bereavement, but loss is of a valued 'object' not a person. There is ambivalence with hostility turned inwards." Remember other reasons of depression, like biochemical, endocrinological, stressful events, learned helplessness, vulnerability factors like physical illness, pain, lack of intimate relationships etc; Anger can be described as a natural automatic response to pain which is experienced as unpleasant and which can be physical or emotional. Anger is elicited when a person feels threatened or rejected and it can be a substitute emotion so the person does not feel pain. This happens consciously or unconsciously.

Bodily aches and pains are common in Depression and these symptoms are also associated with Menopause- natural or induced. Somatic symptoms in the absence of a definitive medical diagnosis are labelled as 'medically unexplained symptoms' or 'worried well'. The management of pain symptoms in the menopause and post-menopausal women with or without co-morbid depression is difficult [1].

The Authors Merrigiola et al. have provided data in an observational study suggesting that menopause can affect pain

depending upon the painful condition experienced by these women. The women in their study had pain syndromes including headache 38%, osteoarticular pain 31%, cervical/lumbar pain 21%,and the pain was present before menopause in a majority 66%, ceased with menopause in 17% and started after menopause in 18% [2]. Those women who choose to have hysterectomy as the option for any of the indications, are they different from those coping with the Mirena, embolisation, endometrial ablation and other hormonal treatments available for some of the causes. It has been found that diagnosing and treating depression among patients having menstrual problems may improve continuity of LNG-IUS treatment of menorrhagia [3].

A thorough literature review of publications over the previous 30 years from its publication in the year 2000, showed that majority of retrospective studies reported an adverse psychological outcome of hysterectomy. However all prospective studies showed that the incidence of depressed mood is higher even before hysterectomy due to pre-existing psychiatric illness, personality and psychosocial factors. Hysterectomy is not a cause of adverse psychological outcome but in women who are depressed due to the emotional response of gynecological symptoms or ovarian deficiency, may improve after hysterectomy. Hysterectomy does not benefit women with prior psychiatric illness [4].

In a multiethnic sample of 934 women, a study of women's health across the nation in USA, concluded that midlife women with a history of major depression are more likely to report heavy bleeding. Preoperative psychiatric status and menstrual blood loss are predictors of outcome of surgery. Significant numbers of women complaining of menorrhagia have their measured menstrual blood loss within the normal range. Psychosocial factors can have an impact on them seeking health care [5].

A study from Italy, a country with the lowest rate of hysterectomy in the world found that hysterectomy for benign conditions is performed more frequently in less educated women, in nulliparae, and in women with higher BMI. During hysterectomy for benign conditions, bilateral oopherectomy is more frequent in less educated women and its frequency increases with the woman's age [6]. The level of education has been shown to be related to the ability to understand psychological aspects of problems.

A tendency to manage anger via direct expression (anger-out) is increasingly recognised as influencing responses to pain. Pain exacerbating effects of trait anger-out are contrasted with the apparent pain inhibitory effects of behavioural anger expression exhibited in anger-provoking contexts [7].

Anger and how it is regulated appears to affect acute and chronic pain intensity. It is believed that suppressing or inhibiting the verbal or physical expression of anger is related to increased pain severity. Inhibiting anger expression during a provocative event may increase perceived pain at a later time [8]. Same authors in a 2011 paper have said that Hysterectomy and other surgeries have been known to be related to chronic pain related to surgery following the operation. It has been found that chronic post-operative pain after hysterectomy is present in 17-32% of women. And the underlying individual susceptibility to pain is an important factor [9]. There is a recent survey by a private healthcare provider Nuffield health of 3275 women which found that 1 in 4 women with menopausal symptoms were concerned about their ability to cope with life. 47% were depressed, 37% had anxiety, 67% of UK females felt there was a lack of support or advice on menopause. The Internet as a medium for providing menopause services in the third millennium has been discussed by the authors [10].

Hysterectomy, one of the commonest gynaecological surgeries is accompanied by a lot of psychological morbidity especially depression which could be present prior to surgery, affecting the outcome. Proper assessment of these women prior to hysterectomy is essential to diagnose a psychiatric illness and offer the appropriate treatment which could be psychopharmacology or a talking therapy. Anger, Depression and Pain are related and if these women are identified early and given the right treatment a lot of physical and psychological pain could be avoided. Pain is a predominant symptom felt by these women prior to and after undergoing hysterectomy. Expressing anger-out could help the pain experienced by these women. Should a psychiatric assessment prior to hysterectomy with identification of anger, and pain issues be made a pre-requisite before this surgery is offered.

These women need ongoing treatment and support with menopausal symptoms and where are these services? Secondary or primary care and at present there is paucity of such service provision and in the current climate of commissioning these factors need to be borne in mind.

As further work I am studying a sample of women who have had a hysterectomy and assessing their depression and pain symptoms and comparing them with a control group of age matched women who have an intact uterus to ascertain the extent of morbidity of depression and pain.

There is a paucity of data about service provision in this category of patients.

Acknowledgements

I am grateful to all my patients who have helped me to develop an astute sense to listen to them and understand their problems and all colleagues who have been responsible for my training.

References

1. Alexander JL, Dennerstein L, Woods NF, Halbreich U, Kotz K, et al. (2007) Arthralgias, bodily aches and pains and somatic complaints in midlife women: aetiology, pathophysiology and differential diagnosis. Expert review of Neurotherapeutics 7: 515-526.
2. Meriggiola MC, Nanni M, Bachiocco V, Vodo S, Aloisi AM (2012) Menopause affects pain depending on pain type and characteristics. Menopause 19: 517-523.
3. Elovainio M, Teperi J, Aalto AM, Grenman S, Kivelä A, et al. (2007) Depressive symptoms as predictors of discontinuation of treatment of menorrhagia by levonorgestrel-releasing intrauterine system. Int J Behav Med 14: 70-75.
4. Khastgir G, Studd JW, Catalan J (2000) The psychological outcome of hysterectomy. Gynecol Endocrinol 14: 132-141.
5. Bromberger JT, Schott LL, Matthews KA, Kravitz HM, Randolph JF Jr, et al. (2012) Association of past and recent major depression and menstrual characteristics in midlife: Study of Women's Health Across the Nation. Menopause 19: 959-966.
6. Progetto Menopausa Italia Study Group1 (2000) Determinants of hysterectomy and oophorectomy in women attending menopause clinics in Italy. Maturitas 36: 19-25.
7. Bruehl S, Chung OY, Burns JW (2006) Anger expression and pain: an overview of findings and possible mechanisms. J Behav Med 29: 593-606.

8. Burns JW, Quartana PJ, Bruehl S (2008) Anger inhibition and pain: conceptualizations, evidence and new directions. J Behav Med 31: 259-279.

9. Brandsborg B (2012) Pain following hysterectomy: epidemiological and clinical aspects. Dan Med J 59: B4374.

10. Cumming GP, Currie H (2005) The Internet and the menopause consultation: menopause management in the third millennium. J Br Menopause Soc 11: 103-108.