

The Lived Experience of Hospitalized Women Undergoing Hysterectomy: A Phenomenological Study

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Abstract

Background: Hysterectomy is one of the main gynecological procedures which affect a woman's life in numerous ways, including physically, psychologically, socially, and sexually. Following hysterectomy, these effects on the women's physical and mental health are contradictory, despite improvements in their biopsychosocial function. **The aim of the current study** is to explore the lived experience of hospitalized women undergoing hysterectomy. **Design:** A phenomenological qualitative research design was utilized to achieve the aim of the study. **Sample:** A purposive sample of fifteen women who had a hysterectomy. **Tools for data collection:** three tools were used for data collection; a structured interviewing questionnaire; an unstructured interviewing questionnaire; the digital voice recorder and field notes. **Setting:** The interview was conducted at the high-risk pregnancy unit and gynecological inpatient department at Obstetrics and Gynecological Hospital which is affiliated with Cairo University Hospitals. **Results:** The overall experience as perceived by the participants could be described, within a framework of time sequences, as the following: 1) The immediate reaction towards hysterectomy was reflected by different feelings such as acceptance of the diagnosis, shock, sadness, and depression; 2) Early post-procedure suffering due to physical and psychological factors; 3) Expected later concerns and actual needs such as concern about family and children, sexual concern, need for affections and support from husband, needs for education; 4) Late post-procedures complaints due to fatigability, weight loss, social effects, loss feminine role, anxiety, altered sexual behavior and excitement. **Conclusion:** The current study concluded that hysterectomy has negative physical, psychological, and social impacts on women's lives in this study sample. **Recommendation:** Before women are discharged from the hospital, healthcare professionals in postoperative departments must address these potentially distressing psychological and physical consequences of hysterectomy.

Keywords: hysterectomy, lived experience, physical, psychological, sexual, and social impacts.

Introduction

The uterus represents a great value in the life of every woman, as it is considered a symbol of femininity and fertility. Its removal can be a difficult process for women to face, especially as it involves emotional, psychological, and cultural factors. It may affect the female identity as they perceived change in the body image, the feeling of mutilation of their body, emptiness, and feeling different from other women^[1]. Hysterectomy is considered the

second most common gynecological surgery in the world among women of reproductive age. Worldwide statistics have shown that the prevalence of hysterectomy across 21 states and the United States ranged from 0.2% to 6.3%. While in Egypt, a retrospective study indicated that the incidence of emergency peripartum hysterectomy in Ain-Shams University Maternity Hospital was 149 of 66,306, or 2.24 per 1,000 deliveries. The main

indications for this type of surgery included benign gynecological diseases such as prolapse, abnormal uterine bleeding, fibroids, pelvic pain, abnormal placentation, uterine atony, uncontrolled postpartum hemorrhage and uterine rupture [2,3&4].

A hysterectomy may be performed via a vaginal, abdominal, or laparoscopic approach. In a total hysterectomy, the uterus and cervix are removed. In some cases, both fallopian tubes and ovaries are removed along with the uterus, which is a hysterectomy with bilateral salpingo-oophorectomy. In a subtotal hysterectomy, only the uterus is removed. In a radical hysterectomy, the uterus, cervix, ovaries, oviducts, lymph nodes, and lymph channels are removed. The type of hysterectomy performed depends on the reason for the procedure. In all cases, menstruation permanently stops and a woman loses the ability to bear children [5].

Hysterectomy may be experienced differently by women. It may have positive or negative implications for physical and psychosocial health. It may provide immediate relief from dysfunctional uterine bleeding and pelvic pain or discomfort but affect women's self-image, marital, and social relationships [6]. The research findings showed divergent effects of hysterectomy on women's lives. Some studies revealed general improvements in mental and sexual desire, while other studies revealed negative outcomes on physical, psychological, sexual, and social functioning [7]. Research about the effect of hysterectomy on women's sexual function concluded that most sexual disorders improve after hysterectomy for uterine benign diseases and that most of the women who were

sexually active before the surgery experienced the same or better sexual functioning after the surgery. The purpose of the current study is to explore the lived experience of hospitalized women undergoing hysterectomy [8].

Significance of the study

Hysterectomy is a major surgical procedure that brings with it significant physiological and psychological complications; it may affect women's self-perceptions, self-esteem, and female identity. Based on the literature, there are few studies in Egypt that assess the lived experience of hospitalized women undergoing hysterectomies. The findings of the current study add to the body of knowledge in this neglected area. The results of this study may improve our understanding of this condition and provide women with the adequate support they need. Also, understanding the lived experience of the women undergoing hysterectomy is essential for the health care provider to support the women and design appropriate nursing plans and interventions when caring for such a group.

Aim of the study

The aim of the current study is to explore the lived experience of hospitalized women undergoing hysterectomy.

Research Question

What is the lived experience of hospitalized women undergoing hysterectomy?

Guiding questions

1. What was your experience with a hysterectomy? How did it look?
2. How was the process of hysterectomy experience proceeding?
3. What are the consequences of a hysterectomy?

Unstructured(open-end) in-depth interviews questions

1. Describe your feelings towards undergoing a hysterectomy?
2. Tell me about your experience with this procedure.
3. What are your concerns and needs after this procedure?
4. How did hysterectomy affect your life (self-image, marital, and social relations)?

Subjects and Methods

Research Design

A qualitative research design using the phenomenological approach was used to explore the lived experience of hospitalized women undergoing hysterectomy. Phenomenology is the study that fits well to detect people's experience of a specific phenomenon and is focusing on seeking the essence of human experienced phenomena through the analysis of verbal explanations from the viewpoint of the participants ^[9].

Setting

The study was conducted at the high-risk pregnancy unit and gynecological inpatient department at the Obstetrics and Gynecological Hospital, Kasr El Ainy, which is affiliated with Cairo University Hospitals. Those units included 4 rooms, two rooms for each with 46 beds, 23 for each, and received approximately 7.974 pregnant and non-pregnant women per year, 3987 for each, with different diagnosis such as diabetes, cardiac disease, hypertensive disorder during pregnancy, autoimmune diseases such as systemic lupus and antiphospholipid syndrome, which cause recurrent abortions, hyperemesis gravidarum, placenta abnormalities such as placenta previa and placenta accreta, uterine bleeding, hysterectomy, and ovarian cyst.

Sample

A purposive sample of hospitalized women undergoing hysterectomy who were willing to participate in the current study was included in the study participants for this research. The predetermination of the number of participants in qualitative studies is almost impossible, as the sample size in qualitative designs is not determined by the number of participants but by achieving saturation of data, which is evidenced when no new information is heard about the study phenomenon.

Inclusion criteria: Egyptian hospitalized women underwent hysterectomy with no specific age and voluntarily accepted to participate in the study and giving written informed consent.

Tools for Data Collection

Three tools were utilized for data collection:

Tool (1)-Structured interviewing questionnaire, which included data related to: (a) socio-demographic data which included age, educational level, occupation residence and marital status. (b) Obstetric history and cause of doing a hysterectomy. (c) Medical history. (d) Gynecological history

Tool (2)-Unstructured interviewing questionnaire that included seven open-ended questions related to the lived experience of hospitalized women undergoing hysterectomy.

Tool (3)- The digital voice recorder and field notes. It is an instrument by cell phone (personal mobile phone), as it plays an important role in data collection in qualitative studies. In the case of refusing the audio-digital recording by the participants, handwritten recording by the researcher was used.

Tool validity and reliability

The tools of data collection were given to 5 experts in the field of maternity nursing to test the content validity of the tool and clarify the sentences as well as the appropriateness of the content. Modification of the tools was done accordingly. The reliability of the tools was tested using Cronbach's alpha test, and the score was highly reliable (0.89) for tools (2), which check the tools for relevance, comprehensiveness, and clarity. The reliability of the tools was tested using split-half methods ($r = 0.88$). This method was used to evaluate the homogeneity of the tool.

Ethical Considerations

Upon receiving the formal approval from the Research Ethics Committee of the Faculty of Nursing at Cairo University (Ethics code, 2020-38), the researcher introduce herself to women who met the inclusion criteria and inform them about the purpose of this study in order to obtain their acceptance to participate in this study. Written consent was obtained from the women who agree to participate in the study. Also, anonymity and confidentiality are assured through coding the data. Participants were assured that their personal data was not used for other research purposes without their permission

Procedures

Once permission was granted to proceed with the proposed study, women who met the inclusion criteria of the study were interviewed. Direct face-face contact was initiated through individual interviews; every participant was interviewed individually three times. And the final interview was through a telephone call three months after discharge from the hospital. Each interview session ranged from 35 to 40

minutes and was conducted in the native language of the participants. The data collection lasted one year from September 2020 to August 2021. A quiet place in the high-risk pregnancy unit and gynecological department in the conference room was used to conduct the interviews.

The first individual interview session concentrated on a verbal explanation of the nature and purpose of the study, as well as signing written informed consent for voluntary participation and using the digital voice recorder. Data related to demographic characteristics, obstetrics, medical and gynecological history was obtained. The second and third interviews were guided by open-ended questions. 1. Describe your feelings towards undergoing a hysterectomy. 2. What about your experience during the procedure. 3. What are your concerns and needs after the procedure? The final interview was through telephone call after three months to answer this question (4). How did hysterectomy affect your self-image, marital, and social relations.

Field notes using pen and notes were used for recording any observations that the researcher performed during the interview sessions. Interviews ended when participants exhausted their descriptions of their experience and no new data, categories, or themes were emerging, as well when there were repeated similar observations among participants (data saturation). The researcher contacted each participant after the completion of data analysis through telephone call to review the data interpretation (member checking).

Data Analysis

The data analysis for the current study is based on Colaizzi's 1978 phenomenological method. In this study, the transcription of the audiotape was done by the research investigator in handwriting, word by word, after each interview. The researcher went through the transcripts line by line and word by word very closely, extracting significant statements and coding each of them. Then the codes were merged into categories, which were then clustered together into subthemes, and finally major themes. The integration of the major themes into an exhaustive description of the phenomenon and validating the identified structure and nature of the phenomenon from the participants' descriptions are then done as a final step.

Results

Table (1) represents the participants' socio-demographic characteristics in this study (n = 15). The age range of the participants was 33-49 years, with a mean of 42.60 ± 7.10 years old; more than half of them (66.7%) were living in rural areas, twelve participants out of fifteen completed preparatory and secondary education. Two-thirds of them (73.3%) were working.

Table (2): shows the obstetric history of the participants: 86.6 % of them were multigravida and 53.3% of them were para from (3-4). About, 60% had history of abortion. 80% had living children. Near half of the participants had complication during previous delivery as; postpartum hemorrhage (26.6 %), placenta previa (20%) and obstructed labor (6.7%).

Table (3) represents the participants' medical history. (26.6%) of them had hypertension, (26.6%) had anemia, (20%)

had cardiac disease, diabetes mellitus (20%), autoimmune disease (13.3%), and anemia (13.3%).

Table (4) represents the participants' gynecological history, the most common gynecological history was uncontrolled bleeding, fibroid, pelvic infection, uterine prolapsed, and endometriosis (100%, 86.6%, 86.6%, 33.3% and 13.3 % respectively). The most common indications for hysterectomy were uncontrolled bleeding, history of fibroid, and placenta accrete (100%, 86.6%, and 20%) respectively.

Figure (1) showed four major themes according to lived experience among women with hysterectomy and 13 subthemes.

Theme (1) Immediate reaction towards hysterectomy

Removal of the uterus is a tragic matter that has multiple consequences for the biopsychosocial health of the women undergoing hysterectomy. The reactions of the women towards hysterectomy differ from one another; some women accept the diagnosis of hysterectomy, while others are shocked by the diagnosis.

Sub-theme 1.1: Acceptance of the Diagnosis

The women who accept the diagnosis often suffer from extreme pain or frequent bleeding, which interferes with their social lives and sexual activities. They are in desperate need of a hysterectomy because they are unable to tolerate the heavy bleeding, extreme pain of gynecological conditions and fear of the negative consequences of the gynecological conditions (fibroid) if it left without treatment. "I accepted hysterectomy as many doctors confirmed the diagnosis and informed me if the tumor left without any intervention; it would be enlarged and had

negative consequences on my health” (P1); “...I accepted the diagnosis as I heard that the fibroid may spread to different places in my body” (P15).

Other women accepted the diagnosis as their daily activities were affected by the heavy bleeding and severe pain, and the women wanted to get rid of the heavy bleeding. “When the doctor told me about a hysterectomy, I accepted it because I felt tired from the heavy bleeding that caused anemia for me and affected my daily activities” (P8). Also, some women reported that heavy bleeding affected their sexual relationship with their husbands and their social relationship, so they were eager to have the operation to improve their sexual lives. “I was annoyed because the heavy bleeding affected my sexual activities with my husband, so I want to get rid of the bleeding and pain as I couldn’t live my life due to this bleeding” (P15). Other accepted the diagnosis as they no longer need for child due to death of husband or that she was divorced “I accepted the diagnosis as I was divorced since 1992 and living with my family and didn’t think about re marriage again or having children. My brothers and sisters had children who loved me, and I loved them. If I was women who want to get marriage again or had children, I will be sad” (P2)

Sub theme (1.2) Feeling of shock

On the other hand, for the women who are still of reproductive age and desire children, and who are exposed to emergent removal of the uterus due to postpartum hemorrhage resulting from placental abnormalities, hysterectomy was considered a crisis, as the womb is culturally a symbol of femininity and fertility, and its removal leads to

infertility. “..I was shocked and couldn’t imagine what was happening to me when the doctor told me about a hysterectomy, as I didn’t suffer from any disease before, and suddenly after delivery there was severe bleeding due to placental abnormalities. I felt like I was in a dream, and I couldn’t believe the diagnosis” (P8); “It was a very difficult feeling that I couldn’t describe. The moment in which the doctor told me about the hysterectomy I felt that the world turned black in my eyes” (P13).

Sub theme (1.3) sadness, and depression

Hysterectomy is considered a very important organ for any women, and removal of it can cause complex emotional changes, including depression, anxiety, and sadness. “My psychological status was destroyed, as I always hear in my rural area when a woman has a hysterectomy, her husband will marry another woman” (P10); “I felt down when the doctor told me about hysterectomy as I was afraid for my husband to yearn for children and marry again” (P13).

Theme (2) Early post-procedure suffering

Immediately after hysterectomy, the women expressed multiple post-operative suffering due to physical causes such as incisional pain, poor appetite, insomnia, didn’t pass flatus and wound infection. Also, some participants suffered post- procedure due to negative emotions such as fear of changing the husband- wife relationship.

Sub theme 2.1: Post-procedure suffering due to physical condition

The common suffering for the majority of the participant in the early postoperative period was severe pain at the site of the surgery (Incisional pain). “When people heard about hysterectomy they were scared, but actually I didn’t feel scared; the only

thing that scared me; it was the first time to undergo an operation. The doctor gave me general anesthesia; he excised the uterus. After the operation, I felt severe pain in the abdomen and back” (P2). Other participants suffered from poor appetite, didn’t pass flatus, and insomnia; this may be due to severe pain. Also, wound infection was another cause of suffering after hysterectomy. “When I came out of the operation, I was in an unpleasant condition. I felt like I was dead, I couldn’t move from my bed even I couldn’t move my hand. I stayed four days without passing flatus. I stayed six days without eating anything. My sleep pattern was disrupted, and my family was sad for me” (P6); “I was hospitalized for 24 days after the hysterectomy because the incision was infected and I had to care for the wound three times per day” (P1).

Sub-theme 2.2: Post-procedure suffering due to a psychological condition (disturbed marital relationship)

The common cause of this type of suffering was that women were afraid of changing their intimacy with their husbands. “Immediately after giving birth, I had massive bleeding and I felt that there was something wrong; after a clinical round with a lot of doctors discussing my condition, one of them told me that I should have a hysterectomy due to placental disruption. At this time, I felt my heart stop as I was only 34 years old. My husband signed the consent, and then I entered the operation room. After recovery from the operation, I didn’t know what was going on around me, and I suffered a lot at that time. I thought about my husband, and how he could deal with me” (P6); “I was overthinking our sexual relationship with my husband. Can he

ever again be as joyful as we were before? Can I fulfil him the same way as before? Will I experience any discomfort or pain during our relationship? Will I be able to sexually please my husband?” (P3).

Theme 3: Expected later concerns and actual needs

Hysterectomy can have a significant impact on a woman’s life and husband relation so receiving support from family and friends affected and strengthened women’s confidence in accepting hysterectomy. Need for affections and support from husband was the first need for the women after hysterectomy.

Sub theme 3.1: Concern about family and children

Multiple participants expressed concern regarding their children after hysterectomy, as the limited number of children is stressful for these mothers. The participant and her family had high hopes for their existing children, leading to high levels of fear and stress. “I wanted to go back to my home to see my newborn and other children” (P5); “I was not worried about my self, my first concern was my children, who care about them in my absence” (P1).

Sub- theme 3.2: Sexual concern

In the absence of uterus fear of losing sexual identity and pleasure was from the main concerns of participants after hysterectomy “I need my husband to feel pleasure during sexual intercourse” (P3); “ I was afraid that the operation would have an effect on sexual relations, so I asked the doctor many times about this, and he answered no” (P11).

Sub- theme 3.1: Need for affection and support from the husband

“I need to feel that my husband supported me; he was not as I expected” (P5); “the

most thing I was overwhelmed with after hysterectomy, I show my husband would deal with me. As our relationship was already disturbed before the hysterectomy due to heavy bleeding, all the time my clothes were soaked with blood, and I was very embarrassed. After hysterectomy, I desperately need my husband, especially after losing my important organ” (P3). Some women felt alone and abandoned after having a hysterectomy because their spouses did not provide them with enough support. Women's emotional status with their spouses was hurt by their lack of support, leading to an emotional breakdown between them. “The most important thing for me is to feel that my husband understands me, as I became very sensitive after the operation” (P14).

Sub theme 3.3; Needs for Education

The participants suggest a need for increased awareness with special topics such as (if there is any special diet postoperative, when they can do daily home responsibility and question about sexual relation). “I heard that the incidence of bone weakness increases after the operation. So, I wanted to know if there was a specific diet to avoid this problem. when can I take shower, can I do my daily home responsibility, the belt that I wear when I can take it off, for how long I should wear the elastic stock” (P3); “I wanted to know the optimal time for healing the wound, for how long the pain will continue and when I go back to my home, can I breast feed my baby or there is any contraindication for breastfeeding” (P5).

Theme 4: Late post-procedure complaints

By one month to two months following surgery using telephone call, the participant reported loss of energy, couldn't do the

routine work s usual, some participant suffered from Weight loss

Sub-theme 4.1: Fatigability

“I feel that I have no energy; I'm drowsy all the time” (P2); “I feel fatigued; I couldn't do my routine work as usual” (P3).

Sub-theme 4.2: Weight loss

“I lost weight after the operation, which may be due to a loss of appetite” (P1); “All my family observed that I lost body weight after the operation” (P12).

Sub- theme 4.3: Social Effect

The majority of the participants reported that hysterectomy affect their social relation.

“I was eager to do the operation to get rid of the bleeding, but it affected our relationship as I feel I lost something. I'm in complete, I'm sitting with my kids, I can't feel with them” (P3); “I see myself as incomplete, I afraid that my neighbour knows that I removed the uterus; I feel that I lost my femininity as compared to women” (P4); “I'm depressed I feel insecure when dealing with my husband's family; I'm trying to stay away from anyone who bothers me” (P5).

Sub-theme 4.4: Loss of Feminine Role

Hysterectomy had a negative impact on the body image and self-esteem of the participants, as the female womb is a representation of femininity and fertility. In her own eyes, losing it makes her a "deficient being; in the eye of herself and the people around her. “The hysterectomy had a great effect on my psychological status. I was depressed and I couldn't see myself as any women, I alerted my family not to tell anyone that I had a hysterectomy, as I feel I am not a female anymore” (P3).

Sub-theme 4.5: Anxiety

Multiple participants expressed changing in their psychological status as following:

“I become very tense than before, I get nervous by any little word from my husband” (P3); “I became very sensitive and down. I can’t control my temperament” (P12).

Sub-theme 4.6: Altered sexual behaviors and excitement

Only the young age participants who were caring with the sexual relation, after one to two months by telephone call four participants reported changing in the sexual activity and desire, while two participants reported no changing in the sexual activity and the other didn’t care with such activity. “I haven’t felt desire or arousal during a sexual act; I think this may be due to my high level of anxiety” (P3); “After my hysterectomy I suffered from many sexual problems: no desire, no excitement, no orgasm, and no pleasure” (P5).

Table 1: Distribution of the Participants According to their demographic characteristics(N=15)

Participants Code	Age	Residence	Educational level	Occupation	Marital status
1	47	rural	Can’t read and write	Working	Widow
2	46	rural	primary education	Working	divorced
3	39	rural	preparatory education	Working	Married
4	46	rural	preparatory education	House wife	Married
5	33	rural	secondary education	House wife	Married
6	34	rural	preparatory education	House wife	Married
7	47	rural	secondary education	House wife	Married
8	49	urban	secondary education	Working	Married
9	49	rural	Can’t read and write	Working	Married
10	39	urban	secondary education	Working	Married
11	48	urban	preparatory education	Working	Married
12	35	rural	preparatory education	Working	Married

Participants Code	Age	Residence	Educational level	Occupation	Marital status
13	39	rural	preparatory education	Working	Married
14	42	urban	secondary education	Working	Married
15	36	urban	secondary education	Working	Married

Table(2): Distribution of the Participants According to their obstetric history (N= 15)

Variables	N	%
Gravidity		
Nulligravida	1	6.7
Primigravida	1	6.7
Multigravida	13	86.6
Parity		
Nullipara	1	6.7
Para from (1-2)	6	40
Para from (3-4)	8	53.3
Abortion		
No	6	40
Yes	9	60
Living children		
No	3	20
Yes	12	80
Complications during previous delivery		
None	7	46.7
Obstructed labor	1	6.7
Placenta previa	3	20
Postpartum hemorrhage	4	26.6

Table (3): Distribution of the Participants According to their medical history (N= 15)

Items	N	%
No	2	13.3
Diabetes Mellitus	3	20
Hypertension	4	26.6
Cardiac Disease	3	20
Autoimmune Disease	2	13.3
Anemia	2	26.6

*the number is mutual exclusive

Table (4): Distribution of the Participants According to gynecological history (N=15)

Items	N	%
- History of fibroid	13	86.6
- Uncontrolled bleeding	15	100
- History of uterine prolapse	5	33.3
- History of pelvic infection	13	86.6
- History of endometriosis	2	13.3

N.B: The numbers are not mutually exclusive.

Hysterectomy Experience: Time sequence reaction

Immediate reaction toward hysterectomy	Early post procedure suffering	Late post procedures complaints
<ul style="list-style-type: none"> • Acceptance of The Diagnosis • Feeling of Shock • Sadness, and Depression 	<ul style="list-style-type: none"> • physical suffering (incisional pain, loss of appetite, insomnia, wound infection) • psychological suffering (disturbed marital relationship) 	<ul style="list-style-type: none"> • Fatigability • Weight loss • Social effects • Loss feminine role • Anxiety • Altered sexual behavior and excitement

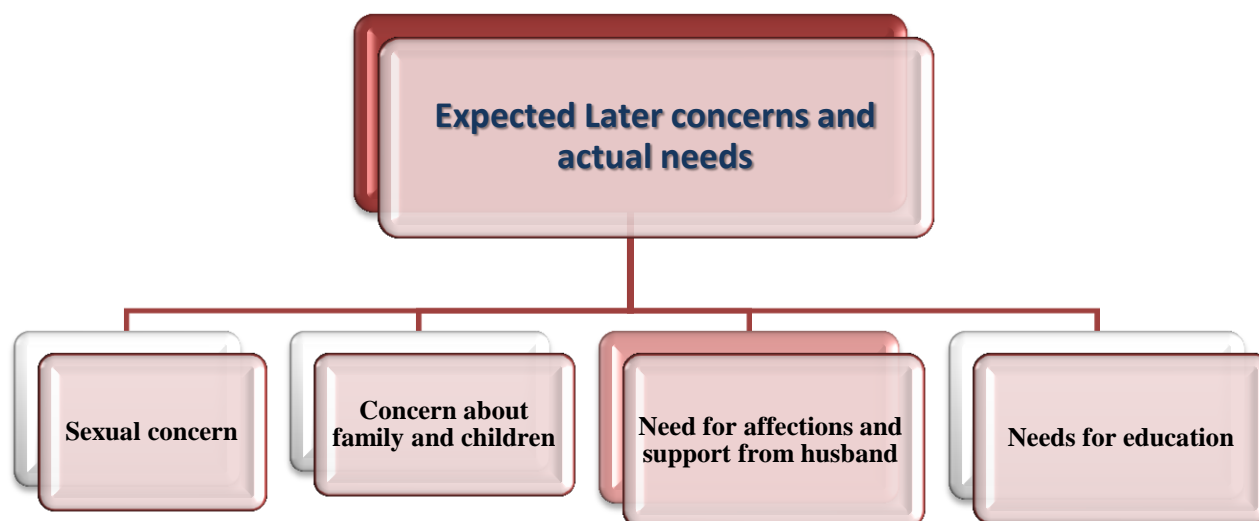


Figure (1) Themes and subthemes of the qualitative analysis

Discussion

The uterus is considered a symbol of femininity and fertility for any woman. Removal of the uterus may be a challenging task for a woman as it encompasses psychological, emotional, and cultural influences. The participants' experiences before and after the hysterectomy varied from one participant to another. The immediate experience toward hysterectomy in this study differed as follows; some participants accepted the diagnosis with satisfaction; others experienced feelings of shock, sadness, and felt depressed. The women who accepted the diagnosis was due to get rid of the bleeding and severe pain which affected their daily activities, sexual and social relation, afraid of the negative consequences of the tumor if left without treatment and no longer need a child due to death of the husband or divorce. The current results are consistent with the study of Janda et al, who found that the majority of women (>96%) did not regret having had the hysterectomy and more than two third of the participants agreed or strongly agreed that they made the right decision to have a hysterectomy^[10].

Also consistent with Li, et al ^[11] who clarified the main consideration before hysterectomy that affects the decision for undergoing hysterectomy as the following disease factors to treat gynecological diseases, fertility factor which affects negatively the decision for undergoing hysterectomy, it can limit young women, especially those who want children, the opportunity to become mothers., and the women may be left out or even abandoned by their husbands because they cannot have children. Bossick et al^[12] clarified that one aspect of the presurgical experience was decision making (personal goals for surgery).The women were accepting the surgery despite a long history of symptoms due to fibroid tumors, especially pain and

discomfort, years of abdominal distension, and heavy menstrual bleeding^[12].

Findings of the current study reported that the participants who expressed feelings of shock, sadness, and depression were the women who underwent emergency hysterectomy due to postpartum hemorrhage resulting from a placental abnormality. This feeling may be due to the surprising situation, as they didn't expect the loss of the uterus. This loss leads to permanent infertility, which causes these women to be divorced or abandoned by their husbands. This result differs from Pilli, Sekweyama, and Kayira^[13], who identified women's experiences following emergency peripartum hysterectomy as joy for being alive but also expressed a loss of womanhood and loss of marital safety.

Regarding the short-term experience immediately after the hysterectomy, the results revealed that the participant suffered from physical conditions such as, incisional pain, poor appetite, didn't pass flatus, and insomnia. This may be due to severe pain at the site of surgery, as well as wound infection. Also, the participants experienced a psychological condition as afraid of changing their intimacy with their husbands. This result is consistent with Mahardika, Setyowati, and Afiyanti^[14], who showed that the physical demands for women following hysterectomy surgery are to deal with pain and sexual issues. Also, there is a similarity between the result of this study and the study of Janda et al ^[10] who clarified the common problems reported by the participant immediately after surgery were nausea and vomiting, regaining bladder or bowel functioning, problems with blood pressure, infection, problems with pain relief, and feeling weak due to blood loss during surgery. Also, this finding was in line with Alshawish, Qadous, and Yamani ^[7] who described the physical changes that happened to the participants after

hysterectomy as the following: pain, insomnia, eating disorder, and immobility. The findings of this study showed that the need for affection and support from the husband was the main concern for the women after the hysterectomy. Some participants expressed their need of husband support as their spouses did not provide them with enough support. These results are congruent with Mahardika et al ^[14] who identified the holistic needs of childbearing age women with hysterectomy. Among these needs are the need to deal with sexual problems and pain and to be cared for by the family. Also, Goudarzi, et al ^[15] concluded that women who have undergone hysterectomy not only experience a significant desire for support from family members, especially their husbands but also from medical professionals and their coworkers.

The present study indicated that concerns about family and children were the main concerns for the participant after the hysterectomy. This finding may indicate that due to losing the opportunity of having another child, the participant showed more intimacy and relationship with the offspring. This finding was contradicted by the study of Goudarzi, et al ^[15] who found that fluctuation in emotional dependency on offspring mean some participant expressed more love for offspring while others reduced attachment to the offspring.

The current study revealed that the need for education regarding diet, daily activity, and sexual intercourse came from women's concerns post-hysterectomy. The current findings were in the same line with Bossick et al ^[12], who describe the experience of women after surgery and clarify that the women had insufficient information regarding complications post-surgery. Also, Gercek, et al ^[16] concluded that women's information needs were high after hysterectomy. Also, sexual concern in this study was the main concern after

hysterectomy. This may be due to afraid from losing the desire after the surgery, this finding was in agreement with Maharlika, et al ^[14] who declared that from holistic needs of childbearing age women with hysterectomy is need to solve sexual problem.

The current findings revealed that hysterectomy had late effects after three months post-operation, such as fatigability and weight loss. This may be due to altered nutritional status and disturbed psychological status. This finding was contradicted by Janda et al ^[10], who stated that the level of energy recovered by 6 weeks after surgery, and contradicted with Alshawish, Qadous, and Yamani ^[7], who reported that some participants expressed an increased in their appetite and weight gain. The findings of the study revealed that hysterectomy affects the social relationships; this may be due to a feeling of incompleteness. This result agreed with that of Goudarzi, et al ^[15], who reported that participants experienced a change in their relationships with people who were important in their lives after hysterectomy.

The study findings revealed a change in the psychological status of the participants in the form of anxiety and aggression when dealing with each other; this may be due to the feeling of losing an important organ. This finding was in agreement with Wilson, Pandeya, Byles, & Mishra ^[17], who concluded that, in the long run, women who have had hysterectomies are at an increased risk of developing depressive symptoms for reasons unrelated to lifestyle or socioeconomic considerations. Also, this finding was in harmony with Alshawish, Qadous, and Yamani ^[7], who reported that depression, accompanied by anxiety, de-socialization, and aggression, was the most common complication after hysterectomy.

The present study indicated that there were varieties in the sexual activity after hysterectomy, some participants reported

alteration in sexual activities and excitement and this may be due to high level of anxiety or feeling with losing something and other reported no change in the sexual activity; this finding was consistent with Alshawish, Qadous, and Yamani ^[7] who reported many participants avoid discussing this topic. Some patients in the study reported sexual effects, and others did not. However, this finding was contradicted by Danesh et al., ^[8] who concluded from their study with on the effect of hysterectomy on women's sexual function that most sexual disorders improve after hysterectomy for uterine benign diseases, and most of the patients who were sexually active before the surgery experienced the same or better sexual functioning after the surgery.

Conclusion

According to the results of the current study it is concluded that hysterectomy is a sensitive operation whose participants need special need before and after surgery as it negatively impacted physically, psychologically and socially on women's life. The overall experience as perceived by the participants could be described as the following: 1) Immediate reaction towards hysterectomy was reflected by different feelings such as acceptance of the diagnosis, feeling of shock, feeling sad, and depression; 2) Early post-procedure suffering due to physical and psychological factors; 3) Expected later concerns and actual needs such as concern about family and children, sexual concern, need for affections and support from the husband, and needs for education; 4) Late post-procedure complaints due to fatigability, weight loss, social effects, loss of feminine role, anxiety, altered sexual behavior, and excitement.

Recommendations

Based on the findings from this research, recommendations can be made to nurses dealing with that condition to support the

women and design appropriate nursing plans and interventions when caring for this group during hospitalization and after discharge. Future research is needed to explore the coping mechanisms of those participants.

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Conflict Of Interest

The author declares no conflict of interest, financial or otherwise.

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