

IMMEDIATE POSTDISCHARGE CONCERNS AND COPING  
OF BENIGN POSTHYSTERECTOMY PATIENTS

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PATRICIA (OLIMASHKO) HARKINS



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Immediate Postdischarge Concerns and Coping  
of Benign Posthysterectomy Patients

by

Patricia (Klimashko) Harkins R.N., B.S.N.

A Thesis submitted to the  
School of Graduate Studies in partial fulfillment of  
the requirements for the degree of  
Master of Nursing

October 1995

St. John's

Newfoundland



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ISBN 0-612-06125-6

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## Abstract

The purpose of this study was to identify and describe the concerns and coping abilities of women following a hysterectomy during their first four weeks after hospital discharge. Findings from this study could assist nurses in determining what kind of information and support are needed to prepare women for their recovery after hospital discharge.

The conceptual framework for this study was based on the theory that women coping with a stressful illness experience, such as having a hysterectomy, is a process that is interpreted differently based on women's perceptions of this event (Cohen & Lazarus, 1979; Lazarus & Folkman, 1984). This would help to explain differences in women's concerns and coping abilities related to having a hysterectomy.

An exploratory descriptive method was employed for this study. The sample consisted of 60 premenopausal women who had an elective benign hysterectomy. Women with complete or partial ovarian tissue remaining were included. Data were collected from women using a two part structured interview guide constructed by the researcher. Section A included data about biological/demographic information, resources for surgery, hospital experience, expectations, and resources available after surgery. Section B identified women's concerns and severity of concerns and coping actions. Descriptive statistics were used to analyze the data.

The results indicated women did have concerns about themselves during their first four weeks at home after hospital discharge. Most women were able to cope with their concerns, particularly in light of resources available to them. The most frequent concerns identified by women were related to bodily integrity and comfort, and emotions and feelings.

Despite the fact women coped fairly well with their concerns during the recovery process, deficiencies were identified. Teaching or information prior to discharge was not sufficient. Lack of information about the recovery process, lack of information about specific concerns, and lack of knowledge related to anatomy and physiology were the three major areas of deficiency identified.

These women returned home early after discharge without benefit of health care support services. Women relied largely on information provided prior to discharge to manage their recovery. Family and friends were also available to help the majority of women after discharge from hospital. However, a number of women also required additional professional services from doctors, nurses, or hospitals. These findings have implications for discharge planning and suggest that women need more information and support services than were provided to them after discharge from hospital. Therefore, nurses need to reassess the kind of information and support services that are provided to women and base discharge planning on patients' concerns.

## Acknowledgements

To the administration and staff of the gynecological unit of the Salvation Army Grace General Hospital I wish to offer my gratitude for their willingness and cooperation to participate in this research. A special thank you is extended to Mrs. Peggy Wicks and Mrs. Betty Tarrant, Preadmission Clinic Nurses, who helped recruit women for this study.

To the women who participated in this study I wish to thank you, for without you, this research would not have been possible.

To my thesis supervisor, Ms. Shirley Solberg, and committee members, Sister Elizabeth Davis and Dr. Albert Kozma, I wish to express my appreciation for their support and guidance during this process. Thanks is also extended to Ms. Maureen Laryea and Dr. Suzan Banoub-Baddour for their help and guidance in the initial stages of this study.

To the Director of St. Clare's School of Nursing, Mrs. Katherine Daley, I wish to express my sincere appreciation for her continued support and encouragement during this process.

Finally, to my husband Charles and son Charles, I give my thanks for all the love, support, encouragement you gave me during this endeavor.

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## CHAPTER I

Hysterectomy is the number one elective surgical procedure performed on women in Canada (Statistics Canada, 1995). In 1991-1992, the latest year for which figures are available, 58,495 hysterectomies were performed on Canadian women for a rate of 334 per 100,000 for abdominal hysterectomy and 93 per 100,000 for vaginal hysterectomy, with the rate for Newfoundland women being comparable to the national average. The monthly average of hysterectomies over the past year from a St. John's hospital, where the greatest number of gynecological surgeries take place, is 47 (see Appendix A).

Changes in the health care delivery system are affecting how individuals are experiencing care within the institutions and agencies in that system. The primary impetus for some of these changes comes from a reduction in the overall health care budget. This reduction in health care dollars has encouraged hospital administrators to look at length of hospital stays. Early discharge after surgery is one strategy to reduce length of hospital stay and thus save money in acute care institutions (Graff, Thomas, Hollingsworth, Cohen, & Rubin, 1992; Hancock & Scott, 1993; Ng & Hogston, 1994). One of the largest groups affected by early discharge, because of the frequency of the surgical procedure, are women who have had an uncomplicated hysterectomy.

The decreased hospital stays for women who have had a

hysterectomy are not caused by budget concerns alone. Even before health care budget cuts, hospital stays for this surgical procedure were beginning to decrease. In Canada an average of 7.3 days for a total abdominal hysterectomy and vaginal hysterectomy are spent in the hospital post-surgery (Statistics Canada, 1995). The average hospital stay for women in the only hospital in St. John's, Newfoundland where women have a hysterectomy performed for nononcological reasons, was even shorter than the national average; five days for an abdominal hysterectomy and three days for a vaginal hysterectomy. One of the reasons for the shorter hospital stays is the administration of antibiotics which significantly alters the number of postoperative complications; however, women are still at risk for other postoperative complications especially those involving the urinary and cardiovascular systems (Cohen, Hollingsworth, & Rubin, 1989; Dicker, Greenspan, et al., 1982; Easterday, Grimes, & Riggs, 1983).

While early discharge after a hysterectomy may have a positive side for the women involved, such as less disruption in family life due to an earlier return to the home, there are some possible negative aspects. The shorter hospital stay, compounded by a same day admission policy that decreases the preoperative period in the hospital as well, has implications for how well prepared the women are to cope with concerns following an uncomplicated hysterectomy and may have an impact on the number and types of concerns they may experience. Additionally, some women may not experience some

of the complications of a hysterectomy until after they have been home and may not know how to cope with these.

Since the majority of hysterectomies are performed for non-oncological reasons, these women are not likely to have access to community health services after early discharge from hospital. Yet as indicated, women with an uncomplicated hysterectomy may have a number of concerns and a need for community health services to cope with these concerns. Therefore, appropriate care and services for these women must be considered when preparing them for discharge and as they continue their recovery at home in the community. Some of the questions to be answered are: How did women who were discharged early after a hysterectomy fare? Did they experience any difficulties in recovering from their surgery? How did they cope with their difficulties? The present study attempts to identify and describe the concerns and coping strategies of a sample of women who had a hysterectomy and were discharged home early after the surgery.

#### Problem Statement

A number of research studies have been designed to examine the consequences of a hysterectomy for women but there are a number of shortcomings with these studies. The majority of studies tend to group all women together without considering the type of hysterectomy performed, reason for surgery, extent of the surgery, or surgical route; yet, varying indications for performing a hysterectomy, use of a



specific surgical technique related to pathology, and possible different complications following specific procedures are reported (Dicker, Greenspan, et al., 1982; Dicker, Scally, et al., 1982; Easterday, Grimes, & Riggs, 1983; Gambone, Reiter, & Lench, 1990; Vessey, Villard-Mackintosh, McPherson, Coulter, & Yeates, 1992). Grouping all types of hysterectomy together presents conceptual and methodological problems related to the sample, conceptual framework, concepts to be studied, and data collection.

Previous studies on the postdischarge consequences of hysterectomy contain mixed samples. These samples include women with and without malignant pathology and with and without oophorectomy (Bernhard, 1992; Cosper, Fuller, & Robinson, 1978; Kuczynski, 1982; Williams, 1976). Quality of life issues related to the problems of menorrhagia, fibroids, and endometriosis are the main issues confronting women when a hysterectomy is performed for one of these benign conditions. While these problems are disruptive to women's lives, they are generally not considered to be life threatening. Women who have experienced a hysterectomy for oncological reasons are confronted with the stress of surgery as well as that of a life threatening event.

Women who have a total hysterectomy, removal of the uterus including the cervix, differ from those women having a hysterectomy with bilateral salpingo-oophorectomy, removal of the uterus and both fallopian tubes and ovaries (Miller & Keane, 1992; Tuomala, 1988). Those women who have their ovaries removed experience immediate menopause due to the

cessation of estrogen and androgen production. This loss of androgens and estrogen after oophorectomy may have an impact on women's sexual desires, response to sexual stimuli, and reaction of genital tissues (Schumacher, 1990; Williamson, 1992). Therefore, grouping all types of hysterectomy together, without consideration of the reason for surgery or extent of surgery, would confound the ability to identify those concerns which are of importance to women having an elective benign hysterectomy. The conceptual framework selected and definition of concepts would differ when studying women coping with surgery for quality of life issues rather than those facing the possibility of death. These differences in women would also have an impact on the tools selected to operationalize concepts.

Hospital stays are usually longer for those women with cancer and for those women having complete removal of their reproductive organs. The longer stay occurs because surgery is more extensive, complications are more common, and further treatment for hormonal replacement or cancer is required. These women are followed closely after discharge from the hospital by physicians, community health nurses, or cancer clinics. Due to increased hospital stays and support services available to help these individuals cope, their recovery may be quite different from women discharged early from hospital without availability of community resources. Time frames for interviewing women and carrying out data collection after discharge from hospital could certainly vary due to differences in length of hospital stays. Women having

longer hospital stays may be interviewed at a later point in their postdischarge recovery than those women having an early discharge. Concerns or problems identified during data collection by these two groups of women could be quite different and not reflective of those having an early discharge. In earlier studies data were collected retrospectively from women anywhere from five and a half weeks to two years after hysterectomy (Cosper et al., 1979; Gould & Wilson-Barnett, 1985; Kuczynski, 1982; Webb, 1983; Williams, 1976). These studies included various aspects of recovery from hysterectomy such as: effect on sexuality, social support available, effect of ethnicity on recovery, fears and myths concerning hysterectomy, counseling necessary, long term recovery, and effect on self-concept.

Finally, there were no studies found which were designed specifically to examine the impact of early discharge from hospital on women who have experienced a hysterectomy. The focus of this study, therefore, is on women having a benign hysterectomy and discharged home early from the hospital.

### Significance to Nursing

Patient education is recognized as an important function in nursing practice. The National League for Nurses (cited in Bille, 1981) advocated the importance of preparing nurses for teaching as early as 1916. So much importance is placed on patient education today that it is included in the curriculum of schools of nursing and it is listed as a

professional component in the Canadian Nurses Association Standards for Practice (1987) and the Quality of Nursing Care Standards for the Association of Registered Nurses of Newfoundland (1991). This emphasis on nurses as patient teachers is because nurses have the closest contact with patients and have more opportunity for patient teaching than any other member of the health care team.

Today the emphasis in Canada's health care system is on promoting health (Epp, 1986) as well as dealing with illness. Henderson (1966), a well known historical figure in nursing education, recognized the nurse's role as patient educator. She felt it was part of the nurse's role to improve patients' levels of understanding and thus promote their health. In order to accomplish this, nurses need to encourage patients to assume responsibility for their health and to become actively involved in their learning process. Media campaign blitzes focusing on health promotion have also contributed to people becoming aware that they can have more responsibility for their own health care. Patients are beginning to understand that knowledge about illness and medical care does not belong to health professionals only. They are better informed and feel they have a right to have questions answered. Therefore, nurses must recognize the importance of their role in health promotion and in developing a teaching relationship with patients.

In addition to promoting health, patient education can help people cope with the stresses of illness. Cohen and Lazarus (1979) indicate there is a cognitive and emotional

focus to coping with the stresses of illness. Information and understanding of the illness by the patient and family can help reduce the harmful and negative effects of illness and increase the positive aspects of recovery, self-image, emotional equilibrium, and relationships with others. These aims are especially significant for surgical patients who are coping with their recovery at home after discharge from hospital.

Teaching patients about their surgical experience may affect the outcome of their recovery by preventing complications, making postoperative recovery less traumatic, shortening hospital stays, and improving patients' lives. A review of 29 studies evaluating patient teaching indicated that 23 of these studies demonstrated benefits to patients (Wilson-Barnett & Osborne, 1983). Patients want to have information about their surgical experience. Findings in previous studies focusing on the postdischarge recovery of women having a hysterectomy indicated women wanted information about their anatomy, physical activities post surgery, what to expect during recovery, complications, and length of recovery (Cosper et al., 1978; Webb, 1983; Webb, 1986).

Patient teaching traditionally has been based on physician input and nurses' perceptions of what patients need to know to cope after surgery. Information of a factual nature such as when to drive, when to go up stairs, or when to return to the doctors is provided. This information, while helpful, does not prepare patients for their immediate

recovery at home after discharge from hospital. When deciding on the kind of information and the method of presentation, it is vital that nurses explore patients' needs.

Patients do not stay long in the acute care setting. As indicated earlier, women having a hysterectomy are being discharged within three to five days after surgery. This means that women having a hysterectomy must begin to cope with recovery at home much earlier than those women having a longer hospitalization, therefore provision needs to be made for continuity of care after discharge. Our health care system as it currently exists, tends to fragment the health care patients receive. Various aspects of the illness experience are dealt with at different locations and by different nurses. This has an impact on the ability of nurses to understand the whole recovery process and therefore provide for continuity of care. If nurses are going to teach patients to cope with their surgical experience it is imperative they understand this experience.

Therefore, there is a need for acute care surgical nurses to better prepare women having a hysterectomy for discharge as well as to understand their patients' concerns after discharge. Nurses need to provide patients with enough information and support to adjust to physical, psychological, and social changes after surgery. Patients need to be prepared about what to expect and how to make responsible decisions about their care. Such information is needed before patients are being discharged home. Identifying

concerns, coping actions, and resources can provide needed data to gain understanding of this early discharge period. Ultimately this information can be used to help make the transition for women from hospital to home one without extreme discomfort, complications, and additional cost to the health care system.

### Purpose of the Study

The main purpose in conducting this study is to identify and describe the concerns of women during their first four weeks postdischarge after having had a benign hysterectomy and having been discharged early from the hospital. A second purpose is to identify coping actions these women used in relation to their concerns, in order to provide added insight into how women were coping with the aftermath of surgery. A third purpose is to identify resources used by women in the community. Considering these women did not generally have access to nurses in the home after discharge, this information could help evaluate whether or not community resources are needed.

Women who have experienced a hysterectomy are returning home to the same environment they left only a week or so earlier. These individuals have experienced a major surgical event and one that can bring about a number of changes to their lives. What significance does having a hysterectomy play in their lives? How does it affect them? What are their concerns about femininity, sexuality, sense of loss,

physical needs, activities, and role changes, during this vulnerable period? How are they coping with these concerns? What resources are available to help them during this time? Interviewing women four weeks after discharge is early enough to capture their experience as they are progressing through their recovery, yet they are well enough physically to be able to participate.

Data collected during the interview could provide nurses with the necessary information to teach patients to cope after hospital discharge and therefore provide the continuity of care necessary from hospital to home. Information could also be gathered about specific community resources that were used by women after discharge and if they were adequate.

Comparing concerns of women in this study with prior studies could determine if possible differences exist between those women having surgery for benign reasons and those women having surgery for cancer or having their ovaries removed. Most importantly, data gathered in this study could provide a foundation for further research related to women having a hysterectomy for benign reasons.

### Research Questions

The main questions this study addressed were:

1. What are the concerns during the first four weeks at home after hospital discharge of women who have had a benign hysterectomy?



2. What concerns are women able to cope with at home during these first four weeks?
3. What concerns are women unable to cope with at home during these first four weeks?
4. What coping actions are used to deal with concerns during these first four weeks?
5. What coping resources are available to these women at home during these first four weeks?

### Definitions

Essential concepts of this study included benign hysterectomy, immediate postdischarge period, concerns, coping actions, and coping resources.

**Benign hysterectomy** was a total hysterectomy, without complete oophorectomy, for reasons other than cancer.

**Immediate postdischarge period** was the first four weeks home after discharge from hospital.

**Concerns** were women's questions, worries, anxieties, or areas of interest related to self.

**Coping actions** were actions that women experiencing a hysterectomy took on their own behalf as they attempted to lessen the impact of a stressful situation.

**Coping resources** were something useful to which women turned to for help or support during their first four weeks after discharge from hospital.

### Conceptual Framework

Two theories were used to develop the conceptual framework for this study: Cohen and Lazarus's (1979) theory of stress dealing with the illness experience; and Lazarus and Folkman's (1984) theory of stress, appraisal, and coping. Early work by Cohen and Lazarus (1979) focused on developing a substantive theory of stress by studying people who were faced with the stress of illness. Cohen and Lazarus (1979) identified specific categories of stressors and coping actions used by people confronted with an illness. Lazarus and Folkman (1984) expanded upon their work and described a formal theory of coping with stress that was general and that could be applied to many life situations. Therefore, the general theory of stress and categories of stressors and coping actions specific to the illness situation were combined to form the conceptual framework for this study.

According to Lazarus and Folkman (1984) stress occurs constantly and is an inevitable aspect of a person's life. Why is it that events can be more stressful for some and not a cause of concern for others? Lazarus and Folkman's (1984) theory suggests these differences occur because a person interprets and gives meaning to events based on his or her own perceptions. Their theory defines psychological stress as "a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and his or her well-being" (p.

19). This definition of psychological stress emphasizes the relationship between the person and the environment and takes into account the person's characteristics and the nature of the environmental event. How a person determines the degree of stress is dependent on their cognitive appraisal.

Cognitive appraisal is thought to be a process of mental activity which involves judgment, discrimination, and activity based on a person's life experiences. Two major factors affecting this appraisal process are related to the person and the situation. Lazarus and Folkman (1984) refer to these variables as person and situation factors. These variables are intertwined and affect one another. Person factors include commitments and beliefs. Commitments are what is important to the person and has meaning for him or her. Beliefs are preexisting notions about reality and serve as a perceptual lens. Beliefs help the person to determine what is fact, how things are in the world, and shape the understanding of the meaning of the event. Situation factors relate to the event and include novelty, predictability, uncertainty, imminence, duration, temporal uncertainty, ambiguity, and timing of the event. After considering these factors the person determines whether the event is threatening and of concern or non-threatening and not of concern. Lazarus and Folkman (1984) describe this as the primary appraisal.

After the primary appraisal, a reexamination of the situation occurs which takes into account a person's

resources for help. This reexamination leads to a reappraisal of the situation, and depending on the amount and kind of resources available helps determine the person's ability to cope with the situation. Categories of coping resources identified include health and energy, positive beliefs, problem-solving, social skills, social support, and material resources (Lazarus & Folkman, 1984).

Coping is defined as "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (Lazarus & Folkman, 1984, p. 178). Coping is considered to be a two fold process in which a person manages or alters the problem with the environment causing distress (problem-focused coping), and regulates the emotional response to the problem (emotion-focused coping).

In Cohen and Lazarus's (1979) theory they identified specific coping modes or actions for the person coping with the stresses of illness. These include information seeking, direct action, inhibition of action, intrapsychic (or cognitive) processes, and support from others. These coping modes seem particularly relevant to the woman experiencing a hysterectomy because of the emphasis on the individual's perception of the event that includes a cognitive and emotional response.

Information seeking, a basic form of coping, is commonly used by people in situations that are new to them, in which they have limited knowledge and in which there is ambiguity. Calling the physician or obtaining information from a medical

book would be examples of this form of coping. Taking medication or doing something about the problem are examples of direct actions. Inhibition of action is the opposite of direct action and involves taking no action about the problem. Denial, avoidance, or use of other defense mechanisms are examples of intrapsychic processes. These are used when the person feels helpless and believes little can be done about the problem. Support from others suggests maintaining and using social relationships be it family, friends, or others.

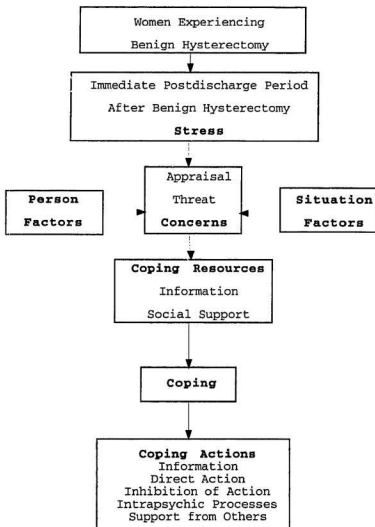
The immediate postdischarge period from hospital to home after hysterectomy can be very stressful for the woman. Many changes are occurring as a result of surgery. She is facing physiological changes to her body brought on by surgery such as loss of a reproductive organ and function and possibly the presence of an incision. Her lifestyle at home may be disrupted by her inability to resume normal roles and functions. Psychological concerns may be present related to feelings about the nature of the surgery. Cohen and Lazarus's (1979) theory identifies specific categories of stresses or threats relative to illness. These are: threats to bodily integrity and comfort, threats to one's self concept and the future, threats to one's emotional equilibrium, and threats to fulfillment of customary roles and activities.

How the woman appraises the event of hysterectomy is dependent on person and situation factors. Person factors that may be relevant are biological and demographic

information, prior medical history, expectations about surgery, and beliefs about surgery. Situation factors such as previous surgery, hospital experience, and resources prior to surgery may be pertinent in the appraisal.

Lazarus and Folkman (1984), as mentioned earlier, include a number of resources used to cope with a stressful event; yet those specifically helpful to the hysterectomy patient are social support and information (Cosper et al., 1978; Gould, 1986; Webb & Wilson-Barnett, 1983b; Williams, 1976). The way a woman copes with concerns at home is determined by her coping resources and deficits. Identification of coping actions and coping resources used to deal with specific concerns can allow for better understanding of how women cope with early discharge.

Five concepts, essential for developing the conceptual framework of this study, include women experiencing a benign hysterectomy, the immediate postdischarge period after hysterectomy, concerns of women having a benign hysterectomy, their coping resources, and their coping actions. The model for this study incorporating these five essential concepts is depicted in Figure 1.



**Figure 1.** Conceptualization of Immediate Postdischarge Period after Benign Hysterectomy. Adapted from Cohen and Lazarus (1979) and Lazarus and Folkman (1984)

## CHAPTER II

## Literature Review

The literature review centered on two main areas: complications after hysterectomy, which encompassed physiological and psychological dimensions; and postdischarge recovery, which provided a review of previous research dealing with women's experiences at home after hysterectomy.

Complications After Hysterectomy

Reported complications after a hysterectomy included both physiological and psychological dimensions. Physiological dimensions included febrile morbidity, cardiovascular problems, urinary problems, gastrointestinal problems, and ovarian problems. Psychological manifestations, which are addressed next, included depression and sexual effects after hysterectomy.

Physiological Dimensions

Hysterectomy has not been performed without some major physiological complications. Complication rate after hysterectomy has been fairly substantial. One fourth to one half of women who had a hysterectomy suffered from one or more complication after surgery (Dicker, Greenspan, et al., 1982; Thompson & Birch, 1981).



Febrile morbidity was the most common complication after hysterectomy. Early studies indicated that fever was more predominant after vaginal than abdominal hysterectomy (Ledger & Child, 1973; White, Wartel, & Wade, 1971). Infection still remains a major postoperative and postdischarge complication today, but the use of prophylactic antibiotics in all vaginal hysterectomies and most abdominal hysterectomies has significantly reduced the incidence and severity of infections as well as hospital length of stay (Hemsell, 1989; Tchabo, Cutting, & Butler, 1985). Specific protocols were established for the use of antibiotics (Micha et al., 1987), but the most important variable was that the initial dose be given immediately before surgery (Dhar, Dhall, & Ayyagari, 1993a, 1983b; Hemsell, 1989; Mittendorf et al., 1983). Current studies indicated febrile morbidity and the rate of infection were higher after abdominal surgery in spite of antibiotics (Dicker, Greenspan, et al., 1982).

The phenomenon of febrile morbidity has not always been associated with infection. There was some indication that febrile morbidity that: occurred within two days after surgery, lacked a positive wound culture, included no other symptoms, and disappeared without treatment, was not due to infection, but was possibly related to the trauma of surgery. Women who later developed infections and required antibiotics were not those who developed febrile morbidity (Hemsell, 1989). Infections were mostly found in the urinary tract, abdominal incision, vaginal or pelvic area, and respiratory system.

Cardiovascular problems associated with hysterectomy were hemorrhage, phlebitis, or thrombophlebitis, possibly resulting in emboli. Ledger and Child's (1973) study reported rates of blood transfusion for abdominal and vaginal hysterectomy at 17 and 13 out of 100 operations, respectively, whereas Dicker and Greenspan's et al. (1982) more recent study cited 15 and 8. Necessity for transfusion was more common with abdominal hysterectomy but this was possibly due to preexisting anemia. Rapid removal of intravenous therapy and increased activity after surgery has led to very low rates of phlebitis and thrombophlebitis.

Movement or injury to organs of the urinary tract and gastrointestinal tract has resulted in urinary retention, bladder and ureter repair, paralytic ileus, bowel repair, and hemorrhage. Dicker and Greenspan et al. (1982) found these unintended surgical problems and procedures more common after an abdominal hysterectomy.

Women who have had their ovaries retained after hysterectomy experienced a complication called "retained ovary syndrome". This was found in premenopausal women who had a total hysterectomy. As many as one out of four women per hundred complained of pain, dyspareunia, and a pelvic mass after hysterectomy (Christ & Lotze, 1975; Richards, 1974). These symptoms could occur early after surgery, however, most often these symptoms began to appear several years after surgery. Results of surgery for this occurrence included pelvic adhesions, cystic ovaries or benign neoplasms. A recent study has suggested another problem,

ovarian failure after hysterectomy, possibly due to severing of blood vessels to the uterus (Riedel, Lehmann-Willenbrock, & Semm, 1986). Early symptoms of this phenomenon caused women to experience climacteric symptoms such as hot flashes and night sweats.

Factors contributing to the complication rate were contamination during surgery, proximity of the urinary tract and bowel, and partiality for thromboembolism after pelvic surgery. Other factors included the indication for surgery, the women's age and general state of health, surgical approach (vaginal or abdominal), physician's experience, and use of prophylactic antibiotics (Amirikia & Evans, 1979; Hemsell, 1989; Parrott, 1972).

In spite of all the complications associated with hysterectomy the risk of death has been relatively low, one to two deaths per 1,000 of all hysterectomies (Dicker, Greenspan, et al., 1983; Ledger & Child, 1973; Tuomala, 1988). Death usually resulted from complications after surgery or effects of oncological disease.

### Psychological Dimensions

A large number of studies have addressed the possible psychological impact on women having a hysterectomy. These studies were primarily focused on the effects of hysterectomy, on the incidence of depression, and possible effects on women's sexuality.

Depression was the most common psychiatric finding.

Early studies confirmed the notion that women were more depressed after hysterectomy than following other kinds of surgery. Lindemann (1941), an early researcher in the area of depression and hysterectomy, interviewed 40 women preoperatively and postoperatively (10 to 18 months after surgery), who had undergone all types of abdominal surgery. He found a 40% depression rate among those of this group who had undergone hysterectomy. Complaints described three weeks after surgery and attributed to depression included sleeplessness, restlessness, agitation, loss of appetite, restriction in activity, and irritability. Drellich and Bieber (1958) studied 23 women who had a hysterectomy for benign and malignant disease at six to twelve months after surgery. These authors reported increased anxiety and emotional stress related to the importance of the uterus as a symbol of femininity and sexuality.

Melody (1962) reviewed the postoperative course of 267 women who had a hysterectomy. Severe depressive illness occurred in only 11 (4%) of the women between the fourth and sixth week following their operation. He suggested that a history of depression had predictive significance in anticipating the psychological outcome of hysterectomy.

Richards's (1973) study indicated 36.5% of 200 women who had a hysterectomy were treated for postoperative depression by their general practitioners. His findings also indicated women under 40, with a history of depression, and no demonstrable disease were most at risk. A later study by Richards (1974) also confirming depression indicated that 50

to 70% of women complained of headaches, dizziness, tiredness, insomnia, hot flushes, and urinary symptoms. These symptoms were used to identify those women with depression.

Wijma's (1984) review of the literature from 1950-1982 on psychological functioning after hysterectomy indicated studies of depression must be interpreted in light of numerous methodological difficulties. These included lack of control or comparison groups, lack of prospective studies, lack of a sufficient and homogeneous sample regarding pathology, lack of consistency in defining and operationalizing the concept of depression, and lack of valid instrument measures.

For the most part, more recent research did not support the early findings on posthysterectomy depression. Meikle, Brody, and Pysh (1977) found no difference in mood disorder of women having a hysterectomy from those women having a cholecystectomy or tubal ligation. Drummond and Field (1984) suggested women may be adjusting to a bereavement or loss and change in body image after removal of the uterus rather than clinical depression. A study conducted by Gould (1986), examining 85 women 11 months after hysterectomy, reported little evidence of depression. In fact, patients reported feeling less anxious, depressed, or fatigued 11 months after the surgery than during the immediate postoperative period.

Recent prospective Canadian studies found that women who had a previous history of depression, lower socioeconomic status, an emergency hysterectomy, and fears about sexual

life or cancer, were at risk for depression. Women having a hysterectomy did not differ from those undergoing cholecystectomy or other pelvic surgery in pre- or postoperative depression scores, but it was felt that gynecologic operations in general were perceived as more stressful than other kinds of surgery. Early and frequently reported symptoms were disturbances of usual activities, fatigue, irritability, indecisiveness, and reduction in libido (Lalinec-Michaud & Engelsmann, 1984, 1985; Lalinec-Michaud, Engelsmann, & Marino, 1988).

Sexuality was not addressed as a separate concept in early studies of the psychological effects of hysterectomy. These studies tended to indicate a negative outcome related to sexuality after hysterectomy. Loss of the uterus and inability to reproduce were linked to feelings of depression, loss of femininity, and sexuality (Dennerstein, Wood, & Barrows, 1977; Drellich & Bieber, 1958).

Later studies produced a more positive picture (Gath, Cooper, & Day, 1982; Ryan, Dennerstein, & Pepperell, 1989). Gould (1986) suggested that the defeminising effects of hysterectomy were less because of women's changing role in society.

Methodological problems similar to those found in studies on depression were noted in a review of studies on sexuality (Bernhard, 1986; Wijma, 1984). Sexuality, which is a broad concept, was defined in many different ways including femininity, sexual desire and satisfaction, sexual response, frequency of intercourse, and sexual relationships. Very few

studies attempted to link the operational definition of the variable with the measurement tool. Humphries (1980) defined sexual adjustment by measuring sexual intercourse. Reliability and validity of instruments used had not been determined. Women selected in the samples of studies also varied in extent of surgery performed and diagnosis. Two important predictors that were suggested as being important to postoperative sexual activity were preoperative sexual activity and sexual satisfaction (Casper et al., 1978; Helstrom, Lundberg, Sorbom, & Backstrom, 1993).

Current prospective studies are directed toward the effects of specific types of surgical procedures (Helstrom et al., 1993; Kilkku, Gronroos, Hirvonen, & Rauramo, 1983; Nathorst-Boos & Von Schoultz, 1993; Williamson, 1991); and counseling (Ananth, 1983; Nadelson, Notman, & Ellis, 1983) on sexual satisfaction, desire, orgasmic ability, and frequency of coitus.

Important factors affecting women's overall psychological reactions to hysterectomy were organic pathology, age, socioeconomic class, stable relationship, significance given to menses, coitus, childbearing and children, and work and leisure time activities (Roeske, 1978). Specific guidance and information before and after surgery were also of significant value (Easterday et al., 1983; Raphael, 1972; Williamson, 1991).

### Postdischarge Recovery

The recovery or convalescence process after hysterectomy has been studied but is a process still not well understood. Lack of understanding was primarily due to not knowing what it means to experience this total process. Early studies tended to focus on particular aspects of this experience, i.e., preoperative phase, postoperative phase, and discharge phase. More recent studies have focused on the experience of having a hysterectomy (Baker, 1989; Chassé, 1991; Davis, 1987; Norris, 1990). A number of studies investigated various aspects of recovery after hysterectomy. These are reviewed and presented in chronological order.

An early exploratory descriptive study by Williams (1976) compared Mexican-American and Anglo women's postoperative responses after hysterectomy. Sixty-four women, who had benign hysterectomies, with and without oophorectomy, were interviewed 19 weeks after discharge. Findings from interviews of both ethnic groups indicated the most stress producing symptoms were bladder difficulties, feeling fragile, nervousness, crying and tearfulness, hot flashes, and weakness and tiredness. Sexual activity was comparable to what it was before surgery. A lack of information related to what to expect and why after surgery was noted in the study. Most women were found to be able to resume household activities four weeks after surgery.

Cosper, Fuller, and Robinson (1978) interviewed 40 women



having a hysterectomy for benign and malignant pathology five and a half weeks after discharge. Retrospective and self-reported data were collected about women's physical changes, emotional changes, changes in sexuality, and fears and beliefs. The main purpose, however, was to describe this posthospitalization period with reference to women's feelings of sexuality and fears and myths before and after surgery. Seventy-five percent of the women expressed: relief the surgery was over, positive feelings about femininity, happiness that sexual desire had returned, and no significant emotional changes. Physical disruptions such as sleeping difficulties, diminished appetite, elimination disturbances, decreased energy level, inability to carry out household duties, and ability to resume leisure time activities were problematic after one week, but were resolved by five and a half weeks. Forty percent of the sample (16 out of 40) wanted additional information the first week at home about physical and sexual activities. Primary concerns included the incision, vaginal infection and discharge, gas pains, and constipation.

Kuczynski (1982), using structured and unstructured tools, measured depression, perception of aftereffects of surgery, life events, and problems encountered by 24 women two and four months after having a hysterectomy for either benign or malignant conditions. The main purpose of this exploratory study, however, was to identify the problems posthysterectomy women encountered after discharge from hospital and to develop guidelines for counseling. Similar

significant problems were identified to the above studies, but in addition weight change, insomnia, lack of concentration, and loss of appetite were identified. Women were also asked about the actions they took to cope with the problems. Low degree of depression, high accuracy of perception about surgery, and no change in sexual activity were also reported. Results of this study must be considered with respect to the small sample size.

Webb (1983), using a quasi-experimental design and Lazarus's model of coping as the conceptual framework, studied 150 women undergoing hysterectomy without oophorectomy for benign conditions. Data collected on experiences in the first four months after hysterectomy, assessed the influence of personality variables and social support on recovery, and evaluated the effectiveness of a teaching session related to the recovery process. The majority of women expressed a positive opinion about surgical outcome. Biographical, dispositional variables, myths, counseling, and social support did not appear to significantly affect the recovery of the experimental (those receiving a teaching session) or control group. The effects of surgery on self-concept or depression contradicted early studies of women's psychological problems after hysterectomy. Eighty three percent of the women felt their sex life was as good or better after surgery compared with before surgery (Webb & Wilson-Barnett, 1983a). Physical complaints were similar to other studies but wound, urinary, and vaginal infections took longer to resolve. The absence of an

identifiable relationship between outcome and counseling was attributed to lack of social support at home (Webb & Wilson-Barnett, 1983b). Webb identified problems regarding data collection, instruments to measure social support and locus of control, and counseling sessions.

A study by Gould and Wilson-Barnett (1985) compared the four month and 11 month recovery period of women following major cardiac surgery and benign hysterectomy (same sample used in Webb's 1983 study) in terms of psychological adjustment and resumption of a wide range of activities. Women having a hysterectomy recovered favorably despite having considerable physical problems, in contrast, recovery from cardiac surgery was considered to be slower and more difficult. Those women having a hysterectomy received help at home for household activities for six to eight weeks. Help and advice prior to discharge was insufficient for both groups.

In a second study of 50 women undergoing hysterectomy for benign conditions Webb (1985) used a phenomenological approach. The kinds of support that women availed themselves of during recovery from hysterectomy were assessed for helpfulness. This study also sought to identify items to construct a tool to measure social support. One group of 25 were interviewed three weeks preoperatively and three months postoperatively; while the second group were interviewed only at the three month postoperative stage to control for the Hawthorne effect. Information deficit and social support were identified as deficiencies in both groups in

postoperative interviews.

Chassé (1991), using a grounded theory approach, studied the experience of women having a hysterectomy. Initially the study focused on the recovery period after hysterectomy, but women wanted to discuss all the events surrounding the experience. As a result the study was modified to include the entire process into the analysis. Ten women having a hysterectomy, aged 24 to 39 years, were interviewed at one and three months posthysterectomy. Data analysis revealed the experience was "composed of three interdependent stages: the disruption of the body, the struggle to preserve wholeness, and the recovery" (Chassé, 1991, p. 90). Women constantly evaluated their symptoms and experiences against their past experiences and those of their friends during this process. Resolution of the experience was influenced by women's satisfaction with their decision to have surgery and their ability to have a successful recovery.

The most recent study of hysterectomy found, was a longitudinal study of 63 adult premenopausal women undergoing hysterectomy for benign pathology with and without oophorectomy (Bernhard, 1992). The purpose of the study was to describe the experience of having a hysterectomy from the women's perspective, but with particular attention to sexuality. Semistructured interview guides and standardized tools were used to gather data related to physical, psychological, social, and sexual aspects of surgery. Data were gathered in face to face interviews on the day before surgery; and four weeks, and three months after surgery.

Concerns after the four week interview were related to resumption of sexual activities, surgical scar, and weight gain or loss. Another questionnaire was then mailed to women two years after surgery. Findings indicated more women had positive outcomes related to physical, emotional, and sexual concerns after surgery than anticipated before surgery; however, less positive outcomes related to emotional and sexual concerns were noted after two years than at three months.

#### Summary

Research indicated that even with improved medical treatment after hysterectomy physiological complications were still a major problem. Infections of the urinary tract, incision, or vaginal area were the most common complications after surgery. These complications were noted more frequently in women having an abdominal hysterectomy.

There was a great deal of controversy about psychological complications. While depression was found as being no more predominant in women having a hysterectomy than in women having other kinds of surgery, there appeared to be confusion about how this concept was measured. Symptoms that were attributed to depression included sleeplessness, restlessness, loss of appetite, and disturbances of usual activities, however, these symptoms could be related to recovery from surgery. Earlier studies that investigated the effects on sexuality of women having a hysterectomy noted

negative effects, however, findings from recent studies were more positive and indicated less significant effects on women's sexuality. The changing status of women in society, particularly related to the childbearing role, was considered to be a key element. In spite of this the effect of a hysterectomy on women's sexuality continued to be the most studied aspect of this surgery.

Studies on postdischarge recovery revealed women recovering at home after hysterectomy were confronted with many physical problems. Those that were predominant included fatigue, bladder problems, vaginal drainage, gastrointestinal problems, incisional concerns, and climacteric symptoms. Anxiety about sex was also of concern, but after resuming this activity most women felt that sexual relations were as good or better than before surgery. The major concern found in these studies, however, was that of lack of information. Women desired specific information about surgery and social support after hospital discharge.

## CHAPTER III

### Methods and Procedures

#### Research Design and Sample

##### Research Design

An exploratory descriptive method was employed in this study in order to identify concerns, coping actions, and coping resources used by patients at home during the immediate discharge period from hospital after they had undergone a benign hysterectomy procedure. Data were collected through interviewing women using a structured interview schedule.

##### Sample

The sample consisted of 60 women, who had an elective benign hysterectomy. Women with complete or partial ovarian tissue remaining were included. The gynecological unit of one local hospital was used to recruit participants for the study.

The sample was purposive (Polit & Hungler, 1991) based on the following criteria:

1. Women of premenopausal age,
2. No psychiatric history, particularly of depression,
3. No significant problems in their medical history,

4. Discharged within a week to ten days after surgery and without major complications, and
5. Having a telephone.

Women who met the above criteria were selected over a five month period from the gynecological unit of a local hospital. Initially, 80 women met the presurgery criteria for the study. The 20 women lost as participants occurred because of: having complete ovarian tissue removed (nine); unwillingness to participate in the interview after discharge (five); having major complications after surgery (three); receiving a positive pathology report for cancer (one); or having surgery other than a hysterectomy (two).

#### Setting and Procedure

Recruitment of potential candidates began in the preadmission clinic. Prospective surgical candidates for a hysterectomy are seen in the clinic several days to a week before admission to hospital for a preadmission workup. The workup includes completion of routine laboratory and radiology studies, history and physical, visit by anesthesiologist, nursing history and assessment, and preoperative teaching. Admission to the hospital takes place the day of surgery. Upon admission patients are taken directly to the operating suite for surgery.

The nurse in the preadmission clinic approached women, who met the presurgical criteria for the study, when they arrived for their preadmission workup. Agreement for the



preadmission clinic nurses to assist in the investigation was obtained from these nurses in cooperation with their nursing supervisors. The nurses then gave the women an explanation letter (see Appendix C) about the study and asked them if the researcher could contact them one to three days postoperatively to arrange a time for data collection. If they agreed they signed a form.

When the researcher obtained the names of the women who were willing to participate in the study from the returned forms, she visited them one to three days after surgery. Women having a vaginal hysterectomy were visited on the first or second postoperative day because they were often discharged within 24 to 48 hours after surgery, while women having an abdominal hysterectomy were visited on the second or third postoperative day because of their longer hospitalization.

Charts were reviewed initially to ensure women met selection criteria. The researcher asked women, meeting criteria, if they understood the study and their participation in the study. If women required a further explanation, the researcher reviewed information provided on the explanation form or consent form. When women agreed to participate they were asked to sign a consent form (see Appendix D).

If women did not meet criteria, the researcher visited them to explain why they would not be included in the study. They were thanked for their willingness to participate in the study.

For the study's purpose, the date women were discharged was obtained by the researcher calling or visiting the gynecological unit. The women were then contacted by telephone three or four weeks after that discharge date to set up an appointment for the interview. Several women were interviewed earlier than four weeks because they were going on holiday during their recovery period. Interviews took place within nine to 37 days after discharge. The average interview occurred 27.1 days after discharge. The length of the interview was usually 45 minutes to an hour.

The researcher interviewed forty women face to face in their homes. The remaining 20 women were interviewed by telephone. Interviews were scheduled with women when family interference was not present or was at a minimum. Initially all interviews were to be face to face with the researcher, but in order to obtain an adequate sample for the study, women living anywhere on the island were included. Those women living beyond a 15 kilometer radius from St. John's were interviewed by telephone.

After data collection was completed, the researcher answered additional questions or addressed concerns by women other than those discussed during the interview. The researcher offered to send a summary of the results of the study to those interested participants. All women were acknowledged for their participation in the study and thanked.

## Data Collection and Analysis

### Data Collection Tool

Data collection tools, used in previous studies of posthospital recovery after hysterectomy to collect information about concerns, were mainly structured and unstructured interview guides or checklists developed by the researchers (Bernhard, 1992; Cosper et al., 1978; Webb, 1983; Williams, 1976). Although these studies used some standard tools to measure particular aspects related to hysterectomy such as depression, mood, sexual functioning, schedule of recent events, and locus of control, checklists and interview guides were used to identify concerns. The reliability and validity of the checklists and interview guides, however, were not determined. The actual tool used to collect data in this study was an interview schedule constructed by the researcher (see Appendix B).

The framework for the construction of this tool was derived from Cohen and Lazarus (1979). Cohen and Lazarus (1979) identified six broad categories of concerns or threats that people dealing with the stress of illness face. These categories included: concerns related to life and fears of dying, concerns related to bodily integrity and comfort, concerns about self concept and the future, concerns about emotions and feelings, concerns about fulfilling customary roles and activities, and concerns related to adjusting to

the hospital physical and social environment. The first category, threat to life and fear of dying, was omitted because the sample in this study had surgery for nononcological reasons. The category addressing concerns related to the hospital environment was also deleted because the timeframe of this study occurred after hospitalization. The remaining four categories formed the framework for the tool.

Concerns in these categories identified by Cohen and Lazarus (1979) were very broad and not geared toward patients who had a hysterectomy. Therefore, content in each category was based on the literature review of posthysterectomy studies. A number of studies contributed to the construction of the tool (Bernhard, 1992; Cosper et al., 1978; Dicker, Greenspan, et al., 1982; Gould, 1986; Graff et al., 1992; Kuczynski, 1982; Webb, 1986; Webb, 1983; Williams, 1976). These studies described concerns posthysterectomy raised by women after discharge from hospital to home.

The structured interview schedule consisted of two sections. Section A included 30 questions related to biological and demographic information, resources for surgery, hospital experience, expectations, and resources available after surgery. Most questions in this section asked for specific responses, however, there were some open ended questions.

Section B included a total of 53 items, divided into four subsections dealing with concerns and type of coping action used to deal with concerns. These subsections

corresponded with the categories identified by Cohen and Lazarus (1979). These subsections included: A- concerns about bodily integrity and comfort, 16 items; B- concerns about self concept and the future, 10 items; C- concerns about emotions and feelings, 13 items; and D- concerns about fulfilling customary roles and activities, 14 items. Questions in this section asked for specific responses. However, open ended questions were included at the end of each subsection to gather additional information.

When the researcher asked questions about concerns in Section B, women were asked first to determine if it was a concern and second to rate the severity of the concern on a rating scale. The rating scale was a four point Likert scale ranging from no problem, mild problem, moderate problem, to severe problem. Using a quantitative differentiation scale allowed for comparisons of individuals during the data analysis and helped identify concerns that were of most difficulty for women. If an item was identified as a concern the related coping action was also identified. These coping actions were coded during the data analysis. Categories of coping actions, as defined in the conceptual framework, included information (IN), direct action (DA), inhibition of action (IA), intrapsychic process (IP), and support (S) (Cohen & Lazarus, 1979).

Each interview was carried out in the same manner. The researcher explained to the women that there were two sections to the interview. Data from Section A were collected first. Women interviewed in person were given a

respondent form with the Likert rating scale and those interviewed by phone were given instructions about the respondent form. Women were then asked questions from Section B. The interview was concluded with women providing additional information, other than what was included on the interview schedule, or they could ask the researcher additional questions.

### Reliability and Validity

Content validity was established during the construction of the tool by including concerns expressed by women who had a hysterectomy from the literature. Face validity of the tool was determined by content experts in gynecologic nursing and research. Three content experts in women's health and one content expert in statistics previewed the tool. Minor changes in wording of questions were suggested. The researcher incorporated these suggestions in the final draft of the data collection tool.

The researcher pretested the tool by carrying out a pilot study with the first five women agreeing to participate in the study. All five women were interviewed using the procedure described earlier. They were able to understand and answer all the questions on the interview schedule without difficulty. No additional information was identified that would need to be included in the tool. Therefore, the interview schedule was not modified. Women used in the pilot study were included in the overall sample for the study.

Interrater reliability for coding of data was determined by having two researchers interpret the same data collected from 15 women, chosen at random. Data related to identification of concerns and coping actions were compared for similarity of ratings for coding (see Appendix B). The interrater reliability for ratings was 0.99. After data collection was completed, internal consistency of the tool was estimated by determining the coefficient alpha for Section B of the tool. The reliability coefficient was 0.67.

#### Data Analysis

Descriptive statistics were used in this study to describe and analyze the data. Those measures that were used included frequency, mode, mean, percentages, and Pearson Product Moment Correlation.

Analysis of data was carried out using the following procedure: coding data; compiling sample characteristics; determining overall frequency of concerns and coping actions; determining frequency of concerns and coping actions in each category; determining individual subject scores of concerns; determining frequency and type of coping resources available; and analyzing qualitative data.

After data were coded they were entered into the computer program, Statistical Package for the Social Sciences (SPSS for Windows). Data collected in Part A, which included biological and demographic information, resources for surgery, hospital experience, expectations, and resources

available after surgery, were then analyzed to provide information about the sample. The frequency of concerns and coping actions identified from Part B of the data collection tool was then calculated for the overall tool and each subsection. Women in the sample, based on scores of concerns tabulated from the Likert scale measuring these concerns, were compared as to what effect biological/demographic factors, resources for surgery, hospital experience, expectations, and resources available after surgery, had in relation to their concerns and coping actions. The final procedure involved tabulating qualitative data that were gathered from women during the interview. Additional concerns not listed in the tool, specific coping actions, coping resources, and other comments were compiled and tabulated according to frequency.

### Ethical Considerations

Guidelines for proper ethical conduct and permission for this study were established before beginning the study. The proposal for this study was submitted to and approved by Memorial University Human Investigation Committee (HIC) of the Faculty of Medicine. Approval was then obtained from the Human Investigation Committee of the institution where the sample was to be obtained. A letter requesting permission to start the data collection was sent to the Director of Nursing in the institution where the study was conducted (see Appendix E).



Women agreeing to participate in the study were assured that all information would remain anonymous and confidential (see Appendix C and Appendix D). Participants were informed they were free to refuse to answer any questions they desired. Interview schedules were available only to the researcher and will be destroyed after completion of the study.

Women were informed that a summary of the findings was available to them on request and that a copy of the completed thesis would be deposited at the Memorial University Health Science Library.

## CHAPTER IV

### Results

The results of this study will be presented in two parts corresponding to the two sections of the interview schedule used for data collection. Section A includes findings related to biological/demographic information, resources for surgery, hospital experience, expectations, and resources available after surgery. Section B presents findings related to women's concerns and severity of concerns and coping actions used by women to lessen the impact of the concern. Descriptive statistics are used to provide results of the study.

#### Section A

##### Biological/demographic Information

Sixty women who met all the sample criteria were included in the study. Their ages ranged from 22 to 51 years with a mean of 39.5 years. The majority of women, 52 (86.7%), were married and in stable relationships. All women, but 1, had children with most women, 22 (36.7%), having 2 children. All were of Christian religion with 26 (43.8%) being Roman Catholic. Most women had either completed high school, 21 (35%), or attended and/or completed university, 27 (45%). Forty-two (70%) women worked outside the home in white collar, 20 (33.8%), or blue collar, 22 (36.6%), occupations (see Figure 2 for a representation of specific sample characteristics).

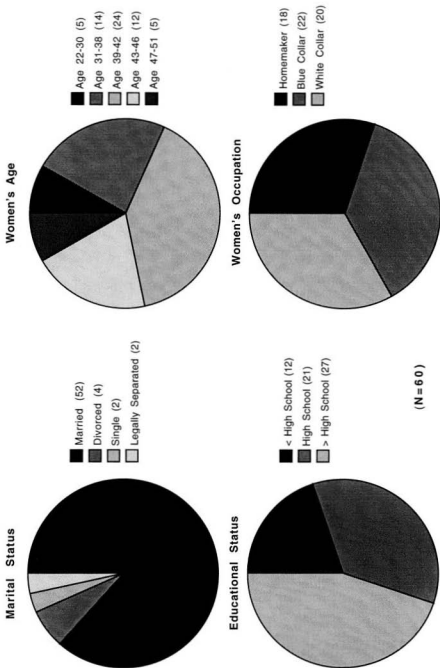


Figure 2 Specific Sample Characteristics

Thirty-seven (61.7%) women knew they needed a hysterectomy for 1 to 4 years; 15 (25%) for less than a year; and 8 (13.3%) for 5 to 12 years. The majority of women, 36 (60%), were diagnosed with menorrhagia, while the second and third most common diagnoses were fibroids and abdominal and pelvic pain (see Figure 3 for complete representation of diagnoses). Diagnoses were determined by referring to the admitting diagnosis on patients' charts. After the decision was made by the women to have surgery, 27 (45%) entered hospital in a month or less, 17 (28.3%) entered in 6 months or less, and 16 (26.7%) entered hospital in a week or less.

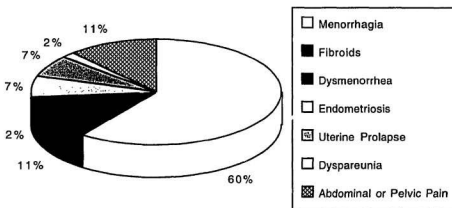


Figure 3 Reason for Hysterectomy (N = 60)

Forty-eight women (80%) had an abdominal hysterectomy and 12 (20%) had a vaginal hysterectomy. Days in hospital ranged from 1 to 10 days, with those women having an abdominal hysterectomy having longer hospital stays. Twenty-one (35%) women were hospitalized for 5 days, followed by 4 days for 13 (21.7%) women, 3 days for 11 (18.3%) women, 6 days for 7 (11.7%) women, 2 days for 3 (5%) women, 7 and 8 days each for 2 (3.3%) women, and 1 day for 1 (1.7%) woman. Those hospitalized longer than 5 days had urinary tract or respiratory problems.

All but 5 (8.3%) women in the sample had previous surgery. Of those having previous surgery, 25 (41.7%) women had surgery which required an abdominal incision, and 30 (50%) had surgery which did not. Surgery which required an abdominal incision included such things as Caesarian section, bowel resection, hiatal hernia repair, cholecystectomy, and appendectomy.

Thirty-five (58.3%) women had current health problems other than those related to their gynecological status. The most common types of health problems included were anemia, hypertension, asthma, ulcers, and degenerative musculoskeletal problems. Women's health problems, however, were generally well controlled with medication or other treatments.

The majority of women in the sample, 39 (65%), indicated they did not have problems in their lives other than gynecological. Of the 21 (35%) women who did cite life problems, 7 (11.7%) were related to financial concerns, 6

(10%) were related to marital problems, 5 (8.3%) were related to the family, and 3 (5%) were related to work.

#### Resources For Surgery

Teaching that was provided to women prior to surgery was given verbally during the preadmission clinic workup. Specific preoperative information related to the routine of surgery such as fasting, preoperative medication, time of surgery, and equipment that might be used, i.e., drains, intravenous, and catheters was included. Women were also given information about what to do immediately after surgery to prevent complications. The nurses discussed with women the importance of deep breathing and coughing, movement of extremities, and receiving pain medication (P. Wicks, personal communication, July 12, 1995).

Fifty-eight (96.7%) women stated they received teaching prior to surgery. Fifty-three (88.3%) of these women felt the teaching was helpful. Positive comments related to teaching included "knew what to expect" and "allayed my fears and anxiety." Those women who did not feel the teaching was helpful, five (8.3%), indicated the "instructions were too general" or they "missed the regular admission process" that allowed them more time to ask questions before surgery (see Table 1 for Resources for Surgery).

Table 1

**Resources For Surgery**

(N=60)

Resource	Frequency	%
Teaching Before Surgery		
Yes	58	96.7
No	2	3.3
Teaching Before Surgery Helpful		
Yes	53	88.3
No	5	8.3
Teaching Before Discharge		
Yes	47	78.3
No	13	21.7
Teaching Before Discharge Helpful		
Yes	36	60.0
No	11	18.3
Prior Surgery Helpful		
Yes	38	63.3
No	17	28.3
Know Other Women Having Hysterectomy		
Yes	57	95.0
No	3	5.0
Talk to Other Women Before Hysterectomy		
Yes	47	78.3
No	13	21.7
Read Anything Before Hysterectomy		
No	39	65.0
Medical Books	10	16.7
Magazines	4	6.7
Other	7	11.7

Teaching prior to discharge included general information about activity, avoidance of constipation, type of activity and implications, sexual activity, pap smear, and return appointment to physician. This information was provided in a list of instructions for gynecology patients and was given to women just prior to discharge (see Appendix F).

Forty-seven (78.3%) women indicated they received teaching before discharge. Thirteen (21.7%) women said they did not receive teaching before discharge. Of the 47 women receiving information prior to discharge, 36 (60%) felt it was helpful, whereas 11 (18.3%) did not. The women cited the "list of do's and don'ts was helpful" but felt it did not address many of their specific concerns after discharge, i.e., "spotting after stitches dissolved" and "urination problems." Many women did not equate handing them a list of instructions with teaching. They wanted further information and explanations. Several women commented they "felt the nurse did not know what happens to you afterwards."

Having prior surgery was thought to be helpful to 38 (63.3%) women, whereas 17 (28.3%) did not find it helpful. Women having surgery felt they knew what to expect from past experiences in relation to routine, anesthetic, pain medication, and incision. Women who had a long history of gynecological problems were happy to have surgery because their "bleeding problems would finally be stopped." Those women who didn't find previous surgery helpful cited previous surgery "too minor" or "not including an incision."

Most women, 57 (95%), knew other women who had a



hysterectomy. Forty-seven (78.3%) women talked to someone who had a hysterectomy. Family members, colleagues, and friends were individuals from whom these women sought advice about hysterectomy. Information from medical books, magazines, or pamphlets was obtained by 21 (35%) women prior to surgery.

### Hospital Experience

The hospital experience was perceived as good or very good by 51 (75%) women in the sample. Only 2 women felt the hospital experience was bad. Comments about the bad hospital experience were "had to keep reminding nurses to give me my insulin" and "couldn't get someone to help me to the bathroom with my IV."

Forty-six women (76.7%) felt they were ready for discharge, while 14 (23.3%) felt they were not. Comments related to women who were not ready for discharge included: "felt weak and hadn't eaten"; "removed my stitches and sent me home"; "went home with a urinary tract infection"; "had pneumonia and was on three medications"; and "gone home in two days, this was too early."

The majority of women, 49 (81.7%), felt they were prepared for their recovery at home because they had someone to help them after discharge and this allowed them to rest and get better. Those women who were not prepared for their recovery at home, 11 (18.3%), indicated this was due to lack

of help, poor understanding of the recovery process, or lack of resources in which to ask questions or gain information.

#### Expectations About Surgery

Questions regarding expectations about having a hysterectomy were related to women's thoughts and feelings about what would happen to them before and after surgery. Women were also asked about their husband's/partner's reactions to them having surgery. They were asked to rate these expectations as bad, neutral, or good. At least half of the women in the sample had bad or neutral feelings prior to and immediately after surgery, but 48 (80%) women had good feelings after surgery. Those women who had bad feelings prior to surgery related these feelings to nervousness and apprehension, while those who had neutral feelings avoided thinking about surgery. After surgery, bad feelings were related to physiological problems such as pain and nausea experienced by women. Husband/partner reactions were good before, 35 (58.3%), and after, 41 (68.3%), surgery (see Table 2).

Table 2

Expectations About Surgery

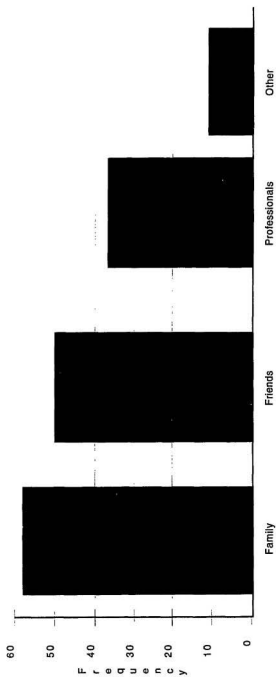
(N=60)

Expectations	Frequency	%
<b>Women Before Surgery</b>		
Bad	14	23.3
Neutral	20	33.3
Good	26	43.3
<b>Women Immediately After Surgery</b>		
Bad	14	23.3
Neutral	17	28.3
Good	29	48.3
<b>Women After Surgery</b>		
Bad	4	6.7
Neutral	8	13.3
Good	48	80.0
<b>Husband/Partner Before Surgery</b>		
Bad	5	8.3
Neutral	12	20.0
Good	35	58.3
<b>Husband/Partner After Surgery</b>		
Bad	0	0.0
Neutral	11	18.3
Good	41	61.8

Resources Available After Surgery

Resources included family, friends, professionals, and other (see Figure 4 for specifics). Family resources included husband/partner, children, and other relatives. Fifty-eight (96.7%) women had family members available to them after surgery. Friends and neighbors were included in the category of friends. Fifty (83.3%) women could rely on friends or neighbors for assistance. Women who sought assistance from hospital clinics, emergency rooms, physicians, or nurses had professional resources available to them. Thirty-seven (61.7%) women did seek help and information from professionals. Thirty-six phone calls or visits to physicians and seven visits to the hospital were made by women after discharge. Three women received visits by Public Health Nurses or Victorian Order of Nurses during their recovery period. Other resources included books or pamphlets, domestic help, or anything not included in the other categories. Eleven (18.3%) women had access to these resources.

Number of Women Experiencing Hysterectomy (N=60)



**Figure 4 Resources Available After Surgery**

## Section B

Analysis of the results related to concerns and coping actions will be presented in this section by categories used in the interview guide. First, the frequency of concerns and severity of concerns of women about bodily integrity and comfort, self concept and the future, emotions and feelings, and fulfilling customary roles and activities will be presented. Secondly, the findings related to coping actions used by the women to address concerns in the above four categories will be discussed.

### Concerns About Bodily Integrity and Comfort

The concerns in this category are presented in order of frequency: fatigue, urination, bowel elimination, change in appetite, wound problems, vaginal discharge and bleeding, general aches and pains, dizziness, hot flashes, legs aching and swelling, sleeping, night sweats, temperature elevation, and weight increase and decrease (see Table 3 for frequency and severity of concerns in this category).

#### Fatigue.

Fatigue was reported by 40 (66.7%) women in the sample. Eighteen women reported the fatigue as being mild, while 15 felt it was moderate and 7 felt it was severe.

Table 3

**Frequency of Concerns About Bodily Integrity and Comfort**  
(N=60)

Concern	Frequency	%	Severity (n)		
			Mild	Moderate	Severe
Fatigue	40	66.7	18	15	7
Urination	32	53.3	18	11	3
Bowel Elimination	29	48.3	11	11	3
Change in Appetite	21	35.0	13	5	3
*Wound (Incision) Problems	19	39.6	9	5	5
Vaginal Discharge	19	31.7	9	4	6
General Aches and Pains	17	28.3	6	7	4
Dizziness	12	20.0	12	0	0
Hot Flashes	12	20.0	8	4	0
Legs Aching & Swelling	11	18.3	11	0	0
Sleeping	11	18.3	6	3	2
Night Sweats	7	11.7	6	1	0
Temperature Elevation	5	8.3	5	0	0
Weight Decrease	3	5.0	2	1	0
Weight Increase	3	5.0	2	0	1

\*Note: % calculated on N=48, number of women in sample having an abdominal hysterectomy

Most women expressed this concern to be most problematic during the first two to three weeks at home. They described fatigue as constantly feeling tired and exhausted. Four women in this group attributed their symptoms to a "low blood count."

#### Urination.

Urination problems were reported by 32 (53.3%) women in the sample. Of these women 18 felt the problem was mild, 11 felt the problem was moderate, and 3 felt the problem was severe. Terminology used by women to describe this concern included "pain, pressure, burning, frequency, and spasms." Twelve women reported having a urinary tract infection either before or after discharge from hospital. One woman, who had a history of urological problems, had a urinary catheter until 13 days after hospital discharge. During the interviews most women felt this problem was resolved or close to resolving.

#### Bowel elimination.

Twenty-nine (48.3%) women reported concerns related to bowel elimination. Eleven women felt the problem to be mild or moderate, but seven felt it was severe. Elimination problems were related to: decreased or increased bowel movements, change in consistency of stool, gas pains or cramps, and pain or soreness on defecation. Most frequently



reported problems were decrease or absence of bowel movements and gas pains. The majority of women found these problems worse during the first two weeks after discharge.

#### Change in appetite.

Problems with eating were reported by 21 (35%) women in the sample. Thirteen women felt the problem was mild, 5 felt it to moderate, and 3 found it to be severe. "Lack of, lost, or decreased appetite" were the comments women made most often about eating. Most women reported eating problems a concern during the first two weeks after discharge.

#### Wound (incision) problems.

Concerns related to the incisional wound were reported by 19 (39.6%) women. This figure was based on a sample of 48 women having an abdominal hysterectomy (external incision). Nine women felt the problem was mild, while 5 felt the problem to be moderate or severe. Problems expressed about the wound by women were related to pain, soreness in incision, stitches, and drainage or bleeding from the incision. At least 7 women reported taking antibiotics for a wound infection. At the time of interviews most women felt their wound was healing.

Vaginal discharge and bleeding.

Vaginal drainage was reported as a concern by 19 (31.7%) women in the sample. Nine women felt the problem to be mild, 6 found it to be severe, and 4 found it to be moderate. Eight reported vaginal drainage was still present during interview. Six women started having bleeding several weeks after discharge.

General aches and pains.

Seventeen (28.3%) women in the sample reported general aches and pains. Seven women found the problem to be moderate, 6 found it mild, and 4 found it to be severe. Most commonly reported symptoms in order of frequency were back pain, stomach pain, and pain on left or right side. Most women reported this problem mild or absent at the time of interview.

Dizziness.

Dizziness was reported as a concern in 12 (20%) women in the sample. They all felt the concern to be mild. Most women reported this to be a problem when changing from a lying or sitting position to one of standing or walking. This problem occurred initially in the recovery period after discharge.

Hot flashes.

Twelve (20%) women reported having hot flashes. Eight women felt the problem to be mild, while four felt it was of moderate concern. Women reported this occurred during the first few weeks at home. Comments related to description of the symptom were "lasted a very short time"; "felt hot, weak, and overcome"; and "sweated." Several older women in the sample suspected this problem was due to the beginning of menopause. Women did not express concern about having hot flashes even though they knew their ovaries were not removed.

Legs aching and swelling.

Leg discomfort was reported by 11 (18.3%) women in the sample. All 11 women felt this concern to be of mild severity. Pain was reported most frequently in calf of leg and thighs. Several women indicated problems present with their legs prior to surgery.

Sleeping.

Eleven (18.3%) women in the sample reported concerns related to sleeping. Six women found it to be of mild concern, three found it to be moderate, and two found it to be severe. Most difficulty with sleeping occurred during the first two weeks after discharge. Two main reasons cited by women for this problem were sleeping too much during the day

and inability to assume a comfortable position due to pain and incision.

#### Night sweats.

Night sweats were reported as a concern by seven (11.7%) women in the sample. Of these women six were mildly concerned and one was moderately concerned. Women did not know whether to attribute this concern to the hot weather or to the surgery.

#### Temperature elevation.

Five (8.3%) women indicated they had a temperature elevation during their first four weeks after discharge. They felt warm, flushed, and uncomfortable. These women measured their temperature orally and the measurements were above normal (37 degrees Centigrade).

#### Weight increase and decrease.

The majority of the six (10%) women who actually had a weight gain or decrease were mildly concerned. Those women who lost weight felt it was due to loss of appetite, whereas those women who gained weight felt it was due to overeating or lack of activity. Weight loss or gain ranged from 1.4 kg (3 pounds) to 6 kg (13 pounds).

### Concerns About Self Concept and the Future

These concerns are presented in order of frequency: gaining weight, regaining sexual desire, starting menopause early, satisfying your sexual partner, partner's reaction to you sexually, losing your femininity, and losing your health (see Table 4 for frequency of concerns and their severity).

#### Gaining weight.

Gaining weight was expressed as a concern by 22 (36.7%) women in the sample. The majority, 13 women, were mildly concerned, but only 4 were severely concerned. This concern was viewed by women as something occurring in the future and not related to weight increase immediately following surgery. Most women who were concerned about gaining weight knew other women who gained weight after a hysterectomy. Women did not know why this happened but thought it had something to do with surgery. Three women felt they would gain weight because they stopped smoking.

#### Regaining sexual desire.

Thirteen (21.7%) women in the study expressed concern about regaining sexual desire, however the majority considered it to be of mild concern. Women offered no explanation why they thought sexual desire would be affected.

Table 4

**Frequency of Concerns About Self-Concept and the Future**  
(N=60)

Concern.	Frequency	%	Severity (n)		
			Mild	Moderate	Severe
Gaining Weight	22	36.7	13	5	4
Regaining Sexual Desire	13	21.7	9	4	0
Starting Menopause Early	9	15.0	8	1	0
Satisfying Sexual Partner	9	15.0	5	3	1
Partner's Reaction Sexually	7	11.7	9	5	5
Losing Your Femininity	4	6.7	3	0	1
Losing Health	2	3.3	1	1	0

**Starting menopause early.**

Nine (15%) women in the sample were concerned about starting menopause early, although their concern was mainly mild in severity. They did not give specific reasons why they thought this would occur.

**Satisfying your sexual partner.**

Sexual satisfaction for the partner was a concern for nine (15%) women in the sample. Only one person was severely concerned about this. Women were worried that sexually they

might perform differently after surgery. They offered no specific reasons why they thought this except that surgery was performed in this area. They wondered if "it would hurt" or asked "what will it feel like." Three women in the sample wondered whether they would be sexually satisfied.

#### Partner's reaction to you sexually.

Seven (11.7%) women expressed concern related to their partner's reaction to them sexually. They wondered if their partners would view them differently having had a hysterectomy. Several women commented that they wondered if they would be as desirable to their partners.

#### Losing your femininity.

Four (6.7%) women were concerned about losing their femininity. Three out of four women were only mildly concerned about this. Comments from women about this concern were related to changes in their physical appearance, i.e., "hairy, saggy, or fat."

#### Losing your health.

Two women (3.3%) were concerned about losing their health. These women expressed concern because they were having problems with urination, infection, and pain. They wondered if they would have a complete recovery.

### Concerns About Emotions and Feelings

The concerns expressed by women in this category according to frequency were: lack of purposeful activity, feeling fragile, feeling anxious about sex, irritability, feelings of depression, nervousness, crying, unusual sadness, ability to concentrate, impatience, feelings of emptiness, and feelings of guilt (see Table 5 for frequency and severity of concerns).

#### Lack of purposeful activity.

Concern related to lack of purposeful activity was expressed by 37 (61.7%) women in the sample. Of these women 21 were mildly concerned, 11 were moderately concerned, and 5 were severely concerned. Women were frustrated with disruption in their daily routines and with having others do things for them. They had difficulty relinquishing their normal roles and assuming the sick role. Several women felt they were being treated as invalids.

#### Feeling fragile.

Twenty-three women (38.3%) in the sample were concerned about feeling fragile. The majority expressed mild concern. This concern was most predominant with women the first few weeks after discharge. This feeling was described as being



Table 5

**Frequency of Concerns About Emotions and Feelings**  
(N=60)

Concern	Frequency	%	Severity (n)		
			Mild	Moderate	Severe
Lack of Purposeful Activity	37	61.7	21	11	5
Feeling Fragile	23	38.3	15	6	2
Feeling Anxious About Sex	21	35.0	13	4	4
Irritability	12	20.0	9	3	0
Feelings of Depression	11	18.3	8	3	0
Nervousness	10	16.7	9	1	0
Crying	10	16.7	5	2	3
Unusual Sadness	10	16.7	8	2	0
Ability to Concentrate	7	11.7	6	1	0
Impatience	5	8.3	4	1	0
Feelings of Emptiness	5	8.3	4	1	0
Feelings of Guilt	2	3.3	2	0	0

"physical and not emotional." Women made comments that they "felt weaker or breakable" or "felt like a porcelain doll." Several women wanted information about changes in their anatomy after surgery, i.e., "what is in the space where my womb was" or "how is everything attached and held up inside me now."

#### Feeling anxious about sex.

Anxiety about sex was a concern for 21 (35%) women in the sample. Seventeen women were mild or moderately concerned, while 4 were severely concerned. Women expressed they had thoughts and feelings about what it would be like. Their thoughts and feelings were related to how they would feel physically during sexual intercourse. The majority of women in the sample were waiting for results of their six week checkup before resuming sexual relations. Women felt their anxiety about resuming sexual relations increased as the day for their checkup drew nearer.

#### Irritability.

Irritability was expressed as a concern by 12 (20%) women in the sample and was mostly thought to be of mild severity. Women thought this feeling was possibly due to cessation of smoking, time when period normally due, or inability to do things for themselves.

Feelings of depression.

Feelings of depression were a concern for 11 (18.3%) women in the sample. The majority of these women were mildly concerned. Women attributed these feelings of depression to "being housebound" and not having friends or family around.

Nervousness.

Nervousness was a concern for 10 (16.7%) women, although mostly a mild one. "Jumpy" or "shaky" were words used to describe this feeling. Women attributed this feeling to concern "about recovery" or "having more time on their hands to worry."

Crying.

Ten (16.7%) women were concerned about crying after surgery. Seven women were only mildly or moderately concerned, while three were severely concerned. This emotion was most predominant in women the first two weeks after discharge. Reasons women gave for crying were their emotional nature, possible nerve problem, frustration at lack of energy, and inability to discipline their children.

Unusual sadness.

Sadness was cited as a concern by 10 (16.7%) women, although it generally was of mild concern. This feeling was most predominant in women the first few weeks after discharge. They described it as a mental process of "feeling down or feeling sorry" about themselves.

Ability to concentrate.

Lack of concentration was a mild concern for most of the seven (11.7%) women who felt this was a concern. This concern was more apparent for women during the first few weeks after discharge from hospital. Reading was the activity in which women most often indicated difficulty.

Impatience.

Impatience was a predominantly mild concern for five (8.3%) women in the sample. Women described themselves as being "touchy." This was a concern in the early discharge period.

Feelings of emptiness.

The majority of the five (8.3%) women who were concerned about feelings of emptiness were mildly concerned. Women related this feeling to "losing something." This loss

was physical and mental for some women. Several women asked for information about changes in their anatomy.

#### Feelings of guilt.

Only two (3.3%) women expressed concern about feeling guilty after surgery. Their feelings were related to not wanting to have surgery or having such major surgery as a hysterectomy.

#### Concerns About Fulfilling Customary Roles and Activities

Specific concerns expressed by women according to frequency were: your job, mother's duties with children, shopping, lifting, driving, sexual activities, climbing stairs, washing and ironing, sports, personal hygiene, and social activities (see Table 6 for frequency and severity of concerns).

#### Your job.

Concerns about returning to work were present for 16 (26.7%) women in the sample. Eight women were mildly concerned, 5 moderately concerned, and 3 severely concerned. Women working outside their homes were more concerned than those at home. Jobs that required lifting or being on their feet for long hours were of most concern to women. Women were worried that their gynecologist would tell

Table 6

**Frequency of Concerns About Fulfilling Customary  
Roles and Activities** (N=60)

Concern	Frequency	%	Severity (n)		
			Mild	Moderate	Severe
Your Job	16	26.7	8	5	3
Mother's Duties w/ Children	12	20.0	7	2	3
Shopping	11	18.3	9	2	0
Lifting	11	18.3	6	4	1
Driving	5	8.3	4	1	0
Sexual Activities	5	8.3	4	1	0
Climbing Stairs	5	8.3	1	4	0
Washing and Ironing	4	6.7	4	0	0
Sports	4	6.7	4	0	0
Personal Hygiene	4	6.7	3	1	0
Social Activities	2	3.3	2	0	0

them they could go back to work at their six week checkup, but they would not feel ready to return. Several women were told by their employers they would be expected to complete job duties just as before surgery when they returned. Two women were told by their employer they could work at jobs with less lifting for awhile.

#### Mother's duties with children.

Concerns related to caring for children were of concern to 12 (20%) women in the sample. Seven women were mildly concerned, 3 severely concerned, and 2 moderately concerned. Kinds of activities mothers were unable to perform with children included attending outside activities, playing sports, lifting, and bathing.

#### Shopping.

Eleven (18.3%) women had concerns about shopping, although most of the concerns were mild. Only three women stated they had not gone shopping at time of interview. Comments women made about shopping were that they tired more easily, got lightheaded, dizzy, weak, or had pain.

#### Lifting.

Concerns related to lifting were expressed by 11 (18.3%) women, although they were mostly mild in severity. The main

problem women had with lifting was in the decision making process. They asked questions like, "When can I start lifting", "What can I lift", and "What will it do to my insides?" A large majority of women had not attempted to lift anything at the time of interview. Many women again expressed concern about having to lift in their jobs.

#### Driving.

Five (8.3%) women were concerned about driving, although only mildly or moderately. A large majority of women resumed driving after two weeks. Those who had problems complained about difficulty getting in and out of the car, pulling on the incision, or stomach aches.

#### Sexual activities.

Resuming sexual activity was of mild or moderate concern for five (8.3%) women in the sample. Only three women in the sample stated they had resumed sexual activity at their interview. Most women, as indicated earlier, were awaiting results of their six week checkup before resuming sexual activity.

#### Climbing stairs.

Five (8.3%) women were mild or moderately concerned about climbing stairs. Pain and discomfort were stated as



being the major problems related to this activity.

#### Washing and ironing.

Washing clothes was a mild concern for four (6.7%) women. Lifting clothes out of the washer or carrying them outside to hang on the line were problems for these women.

#### Sports.

Four (6.7%) women expressed mild concern about resuming sports or exercise activities. The majority of women in the sample had resumed walking. Those women who expressed concern resumed activities such as swimming, walking long distances, or aerobics. Problems resulting from these activities were fatigue and pain.

#### Personal hygiene.

Mild or moderate concern related to personal hygiene needs was present in four (6.7%) women. Problems noted were difficulty getting in and out of the tub or bathing with an open incision.

#### Social activities.

Only two (3.3%) women had mild concerns related to social activities. The majority of women had resumed social

activities without difficulty. Those women who had concerns said they became fatigued easily and could not stay up late.

### Correlation

Women's individual scores of concerns which were constructed from the Likert scale measuring concerns in Part B of the data collection tool were compared with factors in Part A of the data collection tool such as biological/demographic data, resources, and hospital experience. This was done using the Pearson Product Moment Correlation to determine if any relationships existed between any of these factors and women's scores. Age was the only significant factor noted affecting women's scores of concerns. Age was negatively correlated with women's scores of concerns. As age increased the scores of concerns decreased ( $-.4653$ ,  $P < .000$ ).

### Summary of Concerns

All women in the sample identified concerns during the first four weeks after discharge. The least total number of concerns individual women identified was one and the highest number was 25. The greatest frequency of concerns was in the category of concerns about bodily integrity and comfort, followed in frequency by concerns about emotions and feelings, concerns about fulfilling customary roles and activities, and concerns about self concept and the future.

The majority of concerns identified were of mild or moderate concern.

Twelve concerns were identified by at least 25% of women in the sample. Seven out of these concerns related to bodily integrity and comfort, three related to emotions and feelings, one related to self concept and the future, and one related to fulfilling customary roles and activities (see Table 7).

Concerns from all categories which did not appear to be significant (frequency 0 or one) in the sample included difficulty with breathing, aging more rapidly, not having menstrual periods, not being able to have children, feelings of hostility and anger, cleaning your home, cooking, and doing dishes.

Results of the analysis of coping actions used by women to relieve or minimize concerns will be discussed next. Categories of coping actions used to deal with concerns included information, direct action, inhibition of action, intrapsychic process, and support. These were defined and examples were provided in the conceptual framework.

Table 7

**Most Frequent Concerns Identified In All Categories**  
**(N=60)**

Concern	Frequency	%
Fatigue	40	66.7
Lack of Purposeful Activity	37	61.7
Urination	32	53.3
Bowel Elimination	29	48.3
Feeling Fragile	23	38.3
Gaining Weight	22	36.7
Change in Appetite	21	35.0
Feeling Anxious About Sex	21	35.0
*Wound (Incision) Problems	19	39.6
Vaginal Discharge	19	31.7
General Aches and Pains	17	28.3
Your Job	16	26.7

\*Note: % Calculated on N=48, number of women in sample having an abdominal hysterectomy

### Coping Actions Used for Concerns About Bodily Integrity and Comfort

Coping actions used most frequently to minimize concerns about bodily integrity and comfort were taking some type of direct action, inhibition of action, or asking for information (see Table 8).

#### Direct action.

Direct actions were most frequently used to deal with the concerns of fatigue, bowel elimination, general aches and pains, dizziness, hot flashes, legs aching and swelling, night sweats, and temperature elevation. When fatigued, women rested or slept. Actions taken to minimize concerns related to bowel elimination included taking medications, increasing fluids, or changing the diet. Resting or taking pain medication were actions used when women had general aches and pains. Actions taken related to dizziness included changing position, getting up slower, or stopping activity. When experiencing hot flashes or night sweats women took off or changed clothing, opened windows, or went outdoors. Women would elevate their legs or lie down when they had aching or swelling. For temperature elevation women took medication, drank fluids, or took cool showers.

**Coping Actions Used for Concerns About Body Integrity  
and Comfort** (N=60)

Concern	Frequency	Information	Direct Action	Inhibition of Action	Intrapsychic Process	Support
Fatigue	40	1	39	0	0	0
Urination	32	11	9	11	1	0
Bowel Elimination	29	4	22	3	0	0
Change in Appetite	21	1	8	9	2	1
Wound (Incision) Problems	19	13	4	1	0	1
Vaginal Discharge & Bleeding	19	10	1	6	2	0
General Aches and Pains	17	4	9	4	0	0
Dizziness	12	0	10	2	0	0
Hot Flashes	12	0	9	2	1	0
Legs Aching & Swelling	11	0	8	3	0	0
Sleeping	11	1	3	5	2	0
Night Sweats	7	0	6	1	0	0
Temperature Elevation	5	0	4	1	0	0
Weight Decrease	3	0	0	3	0	0
Weight Increase	3	0	1	2	0	0
<b>Total</b>		45	133	53	8	2

### Inhibition of action.

Women most frequently inhibited taking action, i.e., did nothing, when confronted with concerns related to changes in appetite, or weight increase or decrease. Women were divided in their use of actions when dealing with urination concerns. A large number of women felt problems with urination were usual or part of the recovery process and did not take any action, however just as many sought information.

### Information.

When confronted with concerns related to the wound, vaginal drainage or discharge, and urination, women usually obtained information or visited professionals. As discussed earlier many women in the sample had urinary tract or wound infections. Intrapsychic process and support actions were not used frequently in this category of concerns.

### Coping Actions Used for Concerns About Self Concept and The Future

The coping action used most by women most frequently in the category of concerns about self concept and the future was the intrapsychic process. Women worried or thought about concerns related to gaining weight, regaining sexual desire, starting menopause early, satisfying their sexual partner, and their partner's reaction to them sexually. A small

number of women were willing to discuss these concerns and sought support from their husbands/partners or other family members (see Table 9).

Table 9

**Coping Actions Used for Concerns About Self-Concept  
and the Future** (N=60)

Concern	Frequency	Information	Direct Action	Inhibition of Action	Intrapsychic Process	Support
Gaining Weight	22	0	6	5	10	1
Regaining Sexual Desire	13	1	0	0	8	4
Starting Menopause Early	9	0	0	1	6	2
Satisfying Sexual Partner	9	0	0	0	8	1
Partner's Reaction Sexually	7	0	0	0	5	2
Losing Femininity	4	0	0	0	2	2
Losing Health	2	0	0	0	2	0
<b>Total</b>		1	6	6	41	12



### Coping Actions Used for Concerns About Women's Emotions and Feelings

Coping actions used most often by women to deal with concerns about emotions and feelings were taking direct action or resorting to some type of intrapsychic process (see Table 10).

#### Direct action.

Direct action was used as a strategy by women to minimize concerns associated with lack of purposeful activity and feeling fragile. Women would normally perform some activity they were capable of handling when frustrated about normal things they could not do. They walked, knitted, read, or worked on crafts to pass the time away. Feeling fragile caused women to take more time and be more careful.

#### Intrapsychic process.

Women used various intrapsychic processes like thinking, worrying, or being anxious when confronting concerns of feeling anxious about sex, unusual sadness, or feelings of emptiness. Actions in this category were used with some frequency as well by women who had concerns about lack of purposeful activity.

Inhibition of action and support were also used as coping actions, but not in any great degree.

**Coping Actions Used for Concerns About Emotions  
and Feelings** (N=60)

Concern	Frequency	Information	Direct Action	Inhibition of Action	Intrapsychic Process	Support
Lack of Purposeful Activity	37	0	23	1	11	2
Feeling Fragile	23	0	15	4	4	0
Feeling Anxious About Sex	21	0	0	4	15	2
Irritability	12	0	3	4	3	2
Feelings of Depression	11	0	5	1	2	3
Nervousness	10	0	3	4	2	1
Crying	10	0	4	1	4	1
Unusual Sadness	10	0	2	1	5	2
Ability to Concentrate	7	0	3	3	1	0
Impatience	5	0	3	2	0	0
Feelings of Emptiness	5	0	0	0	4	1
Feelings of Guilt	2	0	0	0	2	0
<b>Total</b>		0	61	25	53	14

### Coping Actions Used for Concerns About Fulfilling Customary Roles and Activities

Direct action and intrapsychic process were actions used most commonly by women trying to resume roles and activities (see Table 11).

#### Direct action.

Women took direct actions with concerns related to shopping, driving, and climbing stairs. They took their time or reduced the number and length of their trips.

#### Intrapsychic process.

Concerns that caused women to use actions of an intrapsychic nature were returning to their jobs and resuming sexual activities. They generally were anxious and worried about resuming these activities.

One concern related to household duties, washing and ironing, encouraged women to rely on family support.

### Summary of Coping Actions

Direct action was the most frequent type of coping action used by women overall, but especially in the categories of concerns related to bodily integrity and

Table 11

**Coping Actions Used for Concerns About Fulfilling Customary Roles and Activities**  
(N=60)

Concern	Frequency	Information	Direct Action	Inhibition of Action	Intrapsychic Process	Support
Your Job	16	2	0	1	12	1
Mother's Duties w/ Children	12	0	4	0	2	6
Shopping	11	0	11	0	0	0
Lifting	11	0	5	1	5	0
Driving	5	0	4	1	0	0
Sexual Activities	5	0	1	0	4	0
Climbing Stairs	5	0	5	0	0	0
Washing and Ironing	4	0	1	0	0	3
Sports	4	0	3	1	0	0
Personal Hygiene	4	0	2	0	0	2
Social Activities	2	0	2	0	0	0
<b>Total</b>		2	38	4	23	12

comfort, fulfilling customary roles and activities, and emotions and feelings. The second most frequent type of coping action used by women was the intrapsychic process. This was used when women were confronted with concerns related to self-concept and the future and emotions and feelings. Although inhibition of action was used by women with lesser frequency than the above coping actions, this action was taken when dealing with concerns about bodily integrity and comfort and emotions and feelings. Information seeking was used by women almost exclusively when concerned about their body integrity and comfort. The last coping action and the one used with least frequency was support. It was used equally in all categories, except only twice in the category of bodily integrity and comfort.

### Summary of Results

Sample characteristics indicated the women in this group were relatively homogeneous. Most were married and fairly well educated. The majority had strong family support and few problems in their lives. All were White Caucasians and belonging to a Christian faith.

These women had gynecological problems for a number of years. Most were admitted to hospital in a month or less after decision was made to have surgery. The majority had an abdominal hysterectomy and were hospitalized for five days or less. Hospital experiences for these women were generally positive.

Women in this group had concerns about themselves during their first four weeks at home after hospital discharge. However, most women were able to cope with their concerns, particularly in light of resources available to them at home after surgery. Concerns that were most problematic for women included those they were unable to resolve, those they had insufficient knowledge to deal with, or those that caused them an emotional response.

The most frequent and severe concerns women identified were related to the category of bodily integrity and comfort. Those of most concern were fatigue, urination, bowel elimination, change in appetite, wound problems, vaginal discharge and bleeding, and general aches and pains. The second most frequent category of concerns was related to emotions and feelings. The most common concerns were lack of purposeful activity, feeling fragile, and feeling anxious about sex (see Table 7).

Family, friends, and professional resources were those that were most available and used by women at home to cope with their concerns after discharge from hospital. At the time of the interview most women were happy about their decision to have a hysterectomy and were adjusting to the recovery process.

## CHAPTER V

## Discussion

An integrated model based on Cohen and Lazarus (1979) and Lazarus and Folkman (1984) was used as a framework to describe and explore women's concerns and coping actions after having a benign hysterectomy. The main objective of this study was to examine how these women did in the early postdischarge period. The findings from the study will be discussed in relation to the conceptual framework.

Concerns of Women Posthysterectomy

In the immediate postdischarge period the women in this study reported a number of concerns related to the surgical experience. These women, in spite of their health status, age, diagnosis, hospital experience, and support had concerns similar in type and number with women in prior studies on recovery after hysterectomy. Even though this study included only women who had a benign hysterectomy without complete oöphorectomy, the most frequent problems and concerns identified were similar to those studies including women who had cancer and their ovaries removed. Climacteric symptoms, such as night sweats and hot flashes, and nervousness and crying were less significant, however, with this sample. This was possibly due to women in this sample retaining some ovarian tissue. The women in this study also had more social

support available to them than women in other studies. Why then did women in this study have concerns similar to women in prior studies? Were the groups not so different or were there other influencing factors?

While many differences were apparent between women in this sample and those in prior studies, such as biological and demographic characteristics, diagnosis, extent of surgery, and social support, one major difference was the length of hospital stay. The number of concerns expressed by women in this sample, a group possibly younger, healthier, more educated, and with greater social support, might have been affected by the early discharge. They were returning home after surgery at an earlier point in their recovery than women in prior studies. Even though they had family support they may have needed further help and support from health care professionals. It could also have been that women in this study and women in prior studies did have common concerns which were most evident early after hysterectomy. Women's concerns about having a hysterectomy were also affected by their appraisal of the event. Important variables in this appraisal process were person and situation factors.

#### Person and Situation Factors

Lazarus and Folkman (1984) indicated person and situation factors affect women's appraisal of events, in this case a hysterectomy. Person factors include commitments and



beliefs. "Commitments express what is important to the person, and what has meaning for him or her" (Lazarus & Folkman, 1984, p. 56). These commitments affect choices people make. Having reproductive organs and the capacity to reproduce are meaningful and valued by women. The uterus which normally has great significance to women may have been viewed as a nuisance rather than of importance due to the long duration of the women's gynecological problems. All women in the sample indicated that having menstrual periods and being able to have children were not of concern to them. Webb and Wilson-Barnett (1983a) found similar results in their study. Another factor that may have affected women's lack of concern related to the childbearing role was that 33 (55%) women had previously had a tubal ligation, thus they had already made a decision not to have more children. How women are perceived in society today may have also had some impact in that women are no longer viewed as only childbearers. The fact that a large majority of women worked outside the home suggests they did have other roles to assume.

Beliefs were defined as "personally formed or culturally shared cognitive configurations" (Lazarus & Folkman, 1984, p. 63). Two categories of beliefs identified were: those having to do with personal control, and those having to do with existential concerns. Factors related to beliefs that could have had some relevance on women's perceptions of surgery were level of education, culturally communicated myths, and religious backgrounds. Level of education and

understanding of gynecological problems may have helped women feel they had some control and decision making ability about their situations. However, the number of concerns raised by women about gaining weight, partner's sexual reaction, and regaining sexual desire may have been related to their belief in myths about surgery. Roman Catholic women, who would be expected to have the strongest belief about cessation of child bearing activities and perhaps relate hysterectomy to birth control, were in the majority of those having surgery.

Factors related to the situation and possibly affecting women's perceptions of this event included: novelty, predictability, and event uncertainty; imminence, duration, and temporal uncertainty; and ambiguity and timing of event (Lazarus & Folkman, 1984). All but five women had previous surgery so the experience and the routine of surgery may have not been novel and generally less threatening. Most women had a long history of problems and made a conscious decision when to have surgery so predictability, imminence, temporal uncertainty, ambiguity, and timing of event may not have been significant. Women understood their pathology was benign, and could explain the type of surgery they were having so event uncertainty or outcome being different than expected was unlikely. Duration of hospitalization was fairly predictable, however, the recovery period was not as well defined.

While all the women in this study were premenopausal and had a benign hysterectomy without complete oophorectomy, and were living in a province that is relatively homogeneous

ethnically and culturally, it was anticipated other characteristics would be more heterogeneous. Similar characteristics of marital status, children, level of education, and work status were not anticipated. A sample with wider diversification of characteristics may have provided different results.

### Specific Concerns

#### Physical concerns.

Physical concerns were of utmost importance to these women. This was substantiated by the fact the greatest frequency of concerns was related to bodily integrity and comfort. Six weeks is a generally estimated time frame for complete return of physiological functioning. Interviews took place before this time, therefore it would be expected that physical concerns would be important. Many physiological concerns were problematic only during the first few weeks at home. Cospers et al. (1978) found similar changes between one and five and a half weeks after discharge. While women expected certain physical problems like having a change in their appetite or experiencing aches and pains, there were other problems they did not anticipate.

Fatigue was the most frequent concern identified by women. This is consistent with findings in other studies (Cospers et al., 1978; Gould & Wilson-Barnett, 1983a; Kuczynski, 1982). The frequency of this concern may have

been affected by the number of women in the sample experiencing menorrhagia and anemia prior to surgery. This may have impacted on postdischarge fatigue. However, some women indicated "feeling tired but not as tired prior to surgery." Therefore cessation of menorrhagia might have decreased fatigue in some women.

Urination concerns were common in the women reporting a urinary tract infection. While current medical literature supports the use of antibiotics to reduce incidence of infection, it is not known whether these women were administered medication prior to and after surgery. Even women without infection experienced many urinary problems. Manipulation of the bladder during surgery is known to contribute to these problems. Bladder difficulties were reported as significant in other studies (Casper et al., 1978; Gould & Wilson-Barnett, 1985; Williams, 1976).

Bowel elimination concerns were identified by women as particularly distressing during the first few weeks of recovery in this study and in Kuczynski's (1982). Since most of the women had an abdominal hysterectomy which requires a general anesthetic and manipulation of the bowel during surgery, this may explain the high number of women expressing concern with bowel elimination as well as urinary concerns. Receiving an anesthetic and having the bowel and bladder manipulated affects the physiological return of these normal functions. Due to early discharge many women returned home before the return of bowel functioning, therefore concerns could be anticipated.

Wound problems and vaginal discharge were also of concern to women during their recovery. They had difficulty coping with these concerns because of a lack of information. Women wanted to know what was and was not normal in relation to appearance of the wound and the amount of vaginal discharge. Decision making about these concerns was difficult for women because of not knowing what to expect and how to care for themselves. There were seven women from this group, however, who sought medical care and were receiving antibiotics for wound infections. Lack of knowledge and presence of wound infections probably contributed to the frequency of these concerns.

#### Psychological concerns.

Psychological concerns were the second area of concerns with greatest frequency. Women in this study were not selected if a psychiatric history, particularly of depression, was present. Lack of women with this history probably contributed to the low frequency of depression as a concern. Women's feelings of depression were attributed to disruption in normal activities rather than those of feeling "down." Disturbances of usual activities, fatigue, and irritability were reported, however, and these symptoms have been suggested as stressful reactions to hysterectomy (Lalinec-Michaud & Engelsmann, 1984; Lalinec-Michaud, Engelsmann, & Marino, 1988).

Disturbances in sexuality at this time were not

significant for women based on number of concerns. Factors that may have contributed to this were the large number of women in stable relationships, significance given to menses and childbearing, and lack of resumption of sexual activity. A later prospective study may have provided different results as in other studies (Bernhard, 1992; Gould & Wilson-Barnett, (1985).

Women's self concept did not appear to be significantly affected as evidenced by number of concerns. Again this may be equated with the above factors related to sexuality. This finding was consistent with previous studies (Bernhard, 1992; Cosper et al., 1978; Webb & Wilson-Barnett, 1983b). Women were concerned about gaining weight which certainly related to their self-concept. As previously discussed this was possibly due to their belief in myths about having a hysterectomy.

Women described themselves as feeling fragile during their recovery. Although this concern was categorized with emotions and feelings, women related this feeling to their physical status after surgery. Lack of understanding about changes in their anatomy "how they were held together now" caused them to feel physically weaker and more vulnerable. Women could possibly have had less concern about feeling fragile if teaching about changes in their anatomy were provided.

Social concerns.

Women were pleased to have surgery over and were looking forward to a healthier and a happier life. Similar feelings were expressed by women in prior studies (Bernhard, 1992; Cosper et al., 1978; Kuczynski, 1982). Women were starting to resume most activities at the time of the interview. However, activities that required lifting or strenuous activity were still being done by family members. Most women had not returned to employment outside the home. Cosper et al. (1978) found this in her study, but Williams (1973) reported resumption of activities at four weeks.

Returning to work outside the home was of great concern to women particularly because they had not resumed lifting. Women were worried they were not ready physically to return to work, yet felt the physician would tell them they could return after the six week checkup. Lifting was a frequent part of the duties and since the majority of women had not even begun to lift things at home they were worried about their ability to resume their jobs. Lack of information related to when lifting could begin, what could be lifted, and what injury would occur affected the ability of women to make decisions about lifting. Webb and Wilson-Barnett (1983a) found similar concerns. Lack of information and the significant number of women working outside the home possibly contributed to the frequency of this concern.

Lack of purposeful activity was a major concern for women in this study. Not only were women frustrated with

disruption in their routines, but also with relinquishing their normal roles and assuming the "sick role." Mentally they wanted to assume normal roles and duties, but physically they were unable. They had to find new ways to occupy their time and they found this difficult. Family and others were willing to assume roles women normally held, but in some cases were reluctant to relinquish these roles when women were able to resume them. Chassé (1991) found similar concerns in her study during the "Recovery Stage" when women were adjusting to changes.

#### Coping Resources

The majority of women in this sample had access to resources, information and social support, before and after surgery. Women were generally pleased with teaching given to them in the preadmission clinic, however many women indicated teaching was not given or not helpful prior to discharge. The information sheet given to women on discharge contained valuable information, but it did not address immediate concerns. Women wanted a description of the recovery process and wanted to know what was normal or abnormal during the recovery period. They wanted enough information to be able to make informed decisions about themselves during their recovery at home. Therefore, information provided to women prior to discharge did not appear to be sufficient. Lack of information was also a finding of prior studies on consequences of hysterectomy (Cospers et al., 1978; Kuczyński,



1982; Webb, 1983; Webb, 1986).

Previous studies indicated the importance of social support on recovery after hysterectomy (Webb, 1985; Webb & Wilson-Barnett, 1983b). Women in this sample had a great deal of support from family, friends, and professionals. All but two women had family members available to them for support. They helped women with household duties, taking care of children, and running errands. This allowed women to focus on their recovery, rest, and get back to normal without worrying about usual responsibilities. The low frequencies of concerns related to fulfilling roles and activities probably reflected this.

A significant number of women in the study sought assistance from professionals. Forty-three phone calls or visits were made to physicians or hospital. Other studies have not indicated this type of support so it is impossible to compare and know whether professional assistance in this study was excessive or not. The majority of calls or visits were related to urinary, wound, or bowel elimination concerns. Women indicated lack of information about these concerns, therefore it must be queried whether information would have reduced the need for professional support.

### Coping Actions

Women's coping actions related to concerns were largely influenced by the amount of resources available to them. They were able to deal with or resolve the majority of

concerns confronting them. This was reflected by the frequency of concerns identified by women. The tool used to identify concerns included 53 variables, yet the greatest number of concerns any individual identified was 25. Women most often took direct action or used some sort of intrapsychic process like thinking about or worrying when dealing with concerns. Those concerns that lasted a short time or that were anticipated as normal in the recovery process were not acted upon. Those concerns involving physical problems that women were unable to deal with (urination and wound) and those that involved a greater understanding of anatomy and physiology (feeling fragile) were the concerns with which women were unable to cope. Kuczynski's study (1982) identified similar coping actions: women took action, did nothing, or contacted their physician when troubled enough. This was particularly significant because women in the sample included those, not only recovering from hysterectomy, but also recovering from cobalt therapy and ovarian removal.

## CHAPTER VI

## Conclusions

Despite the fact that women in the study coped fairly well with their concerns during the recovery process, there were deficiencies identified particularly with teaching and professional support. Teaching or information provided prior to discharge was not sufficient for a majority of women. Lack of information about the recovery process, lack of information about specific concerns, and lack of knowledge related to anatomy and physiology were three major areas of deficiency.

Similar deficiencies were identified in studies as early as 1973, yet patient teaching prior to discharge continues to be based on hospital guidelines or nurse's and physician's perceptions of the recovery process. These deficiencies were identified before changes to the health care system such as shortened hospital stays began. Therefore, in light of the impact of these health care changes on women having a hysterectomy, it is imperative that nurses begin to incorporate their patients' perceptions in their discharge planning.

The number of women requiring assistance from professionals was also of concern. Assistance these women required could have been due to lack of information or the early discharge from hospital. Women having a hysterectomy have not had community resources readily available to them in

the past. Health care system changes may warrant evaluating community resources available to these women.

These conclusions which are based on a discussion of the results must be considered with respect to limitations identified in this study and with the implications arising for nursing practice, nursing research, and nursing education.

### Limitations

A number of limitations have been identified in this study related to the sample, data collection and tool used to collect data.

1. The method of sample selection and sample size would limit the generalizability of findings.

2. Homogeneity of the sample in relation to culture, ethnicity, and biological and demographic characteristics limits the ability to note if concerns would have been different or similar with a sample providing wider diversification.

3. Data collection at one week as well as at four weeks after discharge may help to identify more specifically women's concerns after early discharge from those after longer hospitalizations.

4. The interview schedule used to collect data is new and was never used prior to this study. This tool needs further testing.

### Nursing Implications

The main purpose of this study was to identify and describe concerns and coping abilities of women having a benign hysterectomy during their first four weeks after hospital discharge. This time frame was selected so that the impact on women of early discharge from hospital could be discerned. Data collected during this study could ultimately determine if nursing intervention was needed prior to or after discharge from hospital.

The women in this study were well educated and had a high rate of family support and community support. The majority had resources available to them prior to, during, and after surgery. In spite of this, women felt they lacked knowledge about having a hysterectomy and sought professional support after discharge. This has direct implications for nursing practice, research, and education.

### Nursing Practice

Based on results of this study two areas of information that should be incorporated as part of the discharge teaching plan for women are: a description of what to expect during the recovery process and; an explanation of changes in the anatomy and physiology following hysterectomy.

Description of what to expect.

A brief narrative explanation of the recovery process should be provided about what women can expect during their immediate postdischarge period and in the first four weeks. Women need to know that they may experience a variety of concerns relating to many facets of their lives after they have had a hysterectomy. Women must also understand that the timeframe for complete physiological recovery varies among women. Women in this study: experienced fatigue; had difficulty with urination, bowel functioning, vaginal drainage, and wound healing; had difficulty resuming lifting; and were concerned about what to expect when resuming sexual relations.

Women should understand they will experience fatigue after discharge and this may hinder them from resuming normal activities for quite awhile. A coping strategy women used in this study was to pace the activities they performed with rest periods.

Women must be informed that changes in normal urination, i.e., stream, frequency, and pressure may be present for a short time. However, information about the signs and symptoms of a urinary tract infection should also be included. This will allow women to make informed decisions about the normality of urination. Women should also be taught to perform Kegel's exercises to help strengthen the urinary sphincter and reduce urinary frequency.

If women are discharged before their bowel functioning

returns they should understand the physiological reason for this. Coping strategies women used in this study to stimulate peristalsis and bowel functioning were to increase fluids and fiber in their diet. If these strategies failed to bring results they took a mild laxative.

Information about the amount, duration, and changes in type of vaginal drainage during recovery should be explained to women. They should be aware that sometimes when sutures dissolve in the vaginal area they may experience bleeding. This may occur several weeks after surgery.

Those women having an abdominal hysterectomy should be given specific information about the wound (incision). Women in this study had family members care for their wound but felt they needed more information. Women need to understand that if wound edges are approximated and healing well they can bathe normally and leave the incision open to the air. Drainage and open areas in the wound necessitates providing different information. Women should then be taught to cleanse the wound with saline solution and dress the wound with sterile dressings. Wearing loose clothing was found by women to be helpful in preventing irritation of the incision. Taking showers rather than tub baths is also another coping strategy that can be used by women with incisional problems.

Women had difficulty coping with lifting because of lack of knowledge. They need to understand that they should not attempt lifting for several weeks to allow for healing of muscles and ligaments in the lower abdominal area. They can then start lifting light objects like kitchen equipment and

dried laundry. Gradually they should begin lifting heavier items, however if any pain, pressure, or pulling is noted in the lower abdominal area the activity should be stopped. Lifting heavy objects like wet clothes or pushing a vacuum sweeper should not be attempted until near end of the recovery period.

Normal feelings related to sexuality and sexual desire should return as physiological recovery improves. This was important for women to know. Women also need to be told to avoid resuming sexual relations until their physician has performed a vaginal examination to note if internal healing is complete. Pain, bleeding, and discomfort are uncommon unless there is some granulation tissue remaining in the vaginal area which may be sensitive. This state is temporary until complete healing takes place. It is important for women to know that resuming sexual relations will not hurt if they perform the act gently and avoid positions that irritate the incision. Women should know that the majority of women in previous studies indicated their sexual life was the same or better after hysterectomy.

#### Changes in anatomy and physiology.

From some of the concerns and comments by the women it was clear that women did not have an accurate understanding of their anatomy and what anatomical or physiological changes may take place as a result of having a hysterectomy. A clear description of anatomical changes of bladder, bowel,



fallopian tubes, ovaries, and vagina after uterus is removed should be included. An explanation of how hormones continue to be released on a monthly cycle is also necessary. Women need to understand that because hormones continue to be released there should be no effect on menopause, femininity, sexual response, and weight gain.

### Nursing Research

Further nursing research that could be conducted based on this study includes: replicating this study with a more diversified sample; comparing the effect of different teaching plans on women's recovery; evaluating the availability of various community resources on women's recovery; and determining the reliability and validity of the tool used in this study.

Research needs to be conducted with a sample of women having a hysterectomy who are diverse in ethnicity, culture, education, economics, and social support. Their concerns may be quite different from those in this study. Also other concerns not present in this study may be identified. Women could be asked to keep a diary to determine when a concern began and when it was resolved. Maintaining a diary could help to identify if there is a succession or pattern of concerns during the recovery period after early discharge from hospital.

Since lack of information was identified as being important to women in this study, a teaching plan for

discharge after hysterectomy could be developed based on the results of this study and prior research. A comparative study could then be done to compare the effects of a standard teaching plan given to women (see Appendix F) with the one that could be developed from data in this study on women's recovery after hysterectomy. This study would determine whether a structured teaching program does make a difference in women's postdischarge recovery.

Women sought information and support after discharge from professionals. A research study to evaluate types of community resources that could be provided such as teaching by nurses in the community, providing a hot line, or establishing self-help groups might be beneficial to see which resource would be most helpful to women's recovery.

The interview guide used in this study to identify concerns needs further testing for reliability and validity. Carrying out a factor analysis on the tool could help determine construct validity of the tool. Other statistical testing to determine reliability could also be performed. If the reliability and validity were acceptable the tool could then be used to identify concerns in other studies of women having a hysterectomy.

### Nursing Education

Current textbooks rely on a medical model or the nursing process to explain the illness experience. This experience is presented to students in fragmented stages, i.e.,

preoperative care and postoperative care. Little time is spent on explaining what happens after discharge. Usually a few paragraphs are devoted to postdischarge teaching, yet home is where the majority of women's recovery takes place. Early discharge after surgery from acute care settings is becoming more common, therefore it is essential that nurses understand how to prepare patients for their recovery at home. Incorporating results of grounded theory and phenomenological studies (Chassé, 1992; Webb, 1985) about having a hysterectomy when writing textbooks may allow for reflection of patients' views of the experience. This should help to facilitate comprehension of the total experience rather than fragmented stages.

Clinical experiences should also be designed to allow for student's understanding of the hysterectomy experience. Students should care for and follow a patient through as much of the process as possible. This may begin with a student caring for a patient at home in the community, then following the patient through her hysterectomy in the hospital, and returning to the home after discharge. Providing experiences in other settings such as gynecologist's offices and outpatient clinics can also facilitate greater understanding of the recovery process.

Students must be encouraged to develop critical thinking skills, which involves a learning process of questioning, analyzing, and not accepting things at face value. This avoids "learning by rote or tradition" and encourages a research attitude. Students can then be directed to base

their nursing practice on current research and not their own perceptions.

As hospital stays shorten and women are discharged earlier in their recovery back to the community, nurses in the acute care setting and the community must be prepared to care for these women. Current education for these nurses could be provided by developing a program of continuing education. Presenting results of this study would be one example of continuing education. Incorporating results of women's perceptions of hysterectomy could then be included in their discharge planning.

The findings from this study affirm the importance of including women's perceptions about their experience of having a hysterectomy when preparing them for their postdischarge recovery. Incorporating results of nursing research such as in this study can help nursing move toward research based practice and ultimately improve the quality of care provided to patients.

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**Appendix A**

Statistics on Hysterectomy  
1991-1992

Canadian		
	Total	Rate/100,000
Total Abdominal Hysterectomy	45,795	334
Vaginal Hysterectomy	12,700	93

Newfoundland		
Total Abdominal Hysterectomy	1,325	459
Vaginal Hysterectomy	338	117

Note. From Surgical procedures and treatments 1991-1992 (pp.32-33). Annual Health Statistics Division. (Catalogue 82-217). (1995). Ottawa: Statistics Canada.

Hysterectomy Statistics  
 Grace General Hospital  
 St. John's, Newfoundland  
 June 1992-June 1993

	Vaginal	Abdominal	Total
June	4	11	15
July	3	16	19
August	9	18	27
September	6	24	30
October	17	31	48
November	19	45	64
December	5	18	23
January	28	44	72
February	26	38	64
March	27	47	74
April	24	41	65
May	20	36	56
June	15	38	53
<u>Totals</u>	203	407	610

Note. From J. Budgell, personal communication, July (1993).

**Appendix B**

Date:                      Subject Number:

Interview Schedule of Immediate Postdischarge  
Concerns and Coping of  
Benign Posthysterectomy Patients

Section ABiological/demographic information

1. What is your present age?\_\_\_\_\_
2. Do you have children?\_\_\_\_\_
- How many?\_\_\_\_\_
3. What is your current marital status?\_\_\_\_\_
4. Do you have a particular religious affiliation?(Y/N)
- Which religion?\_\_\_\_\_
5. What is your educational status?  
\_\_\_\_\_Less than high school  
\_\_\_\_\_High school  
\_\_\_\_\_Attended university or post-secondary school  
\_\_\_\_\_Completed university or post-secondary school  
(Type of program)\_\_\_\_\_
6. What is your occupation?\_\_\_\_\_
- Are you working at present? (Y/N)\_\_\_\_\_



7. What is your husband's/partner's occupation?

\_\_\_\_\_

Is he working at present?(Y/N)\_\_\_\_\_

8. For how long have you known that you needed a hysterectomy?\_\_\_\_\_

9. What was the reason for your hysterectomy?

(Chart )\_\_\_\_\_

(Woman's explanation)\_\_\_\_\_

10. How soon did you enter hospital after finding out you needed a hysterectomy?\_\_\_\_\_

11. What type of hysterectomy was performed?

(Chart) \_\_\_\_\_

(Woman's explanation)\_\_\_\_\_

What type of incision did you have?\_\_\_\_\_

12. How many days were you in hospital?\_\_\_\_\_

13. Have you had previous surgery?(Y/N)\_\_\_\_\_

(Type)\_\_\_\_\_

14. Do you have other health problems?(Y/N)\_\_\_\_\_

(Type)\_\_\_\_\_

15. Do you have other problems in you life?(Marital, work, children, financial)\_\_\_\_\_

\_\_\_\_\_

#### Resources for surgery

16. Did you receive teaching before surgery?(Y/N)\_\_\_\_\_

Was it helpful or not?\_\_\_\_\_

\_\_\_\_\_

17. Did you receive teaching prior to discharge?(Y/N)\_\_\_\_  
 Was it helpful or not?\_\_\_\_\_
18. Did any prior surgery help you with your hysterectomy?  
 (Y/N)\_\_\_\_\_(How)\_\_\_\_\_
19. Do you know other women that have had hysterectomies?  
 (Y/N)\_\_\_\_\_
20. Did you talk to anyone about hysterectomy prior to  
 surgery?(Y/N)\_\_\_\_\_(Who)\_\_\_\_\_
21. Did you read anything about hysterectomy prior to  
 surgery?(Y/N)\_\_\_\_\_(What)\_\_\_\_\_

#### Hospital experience

22. Which sentence best describes your hospital experience?
- \_\_\_\_\_Very bad
- \_\_\_\_\_Bad
- \_\_\_\_\_Neutral
- \_\_\_\_\_Good
- \_\_\_\_\_Very good
23. Did you feel you were ready to go home the day of  
 discharge?(Y/N)\_\_\_\_\_
24. Now that you have been home for four weeks, do you feel  
 you were prepared for your recovery at home?  
 (Y/N)\_\_\_\_\_(In what way?)\_\_\_\_\_

Expectations (Thoughts about what would happen)

25. What were your expectations before surgery?

\_\_\_\_\_Bad

\_\_\_\_\_Neutral

\_\_\_\_\_Good

26. What were your immediate expectations after surgery?

\_\_\_\_\_Bad

\_\_\_\_\_Neutral

\_\_\_\_\_Good

27. What was your husband's/partner's reaction to you having a hysterectomy?

\_\_\_\_\_Bad

\_\_\_\_\_Neutral

\_\_\_\_\_Good

28. What are your expectations four weeks after surgery?

\_\_\_\_\_Bad

\_\_\_\_\_Neutral

\_\_\_\_\_Good

29. What is your husband's/partner's reactions to you four weeks after surgery?

\_\_\_\_\_Bad

\_\_\_\_\_Neutral

\_\_\_\_\_Good

Resources available after surgery

30. Which resources are available to you at home since discharge? (Y/N) If not, why?

\_\_\_\_\_ Husband or partner  
\_\_\_\_\_ Children  
\_\_\_\_\_ Mother  
\_\_\_\_\_ Other relatives (M/F)  
\_\_\_\_\_ Friend (M/F)  
\_\_\_\_\_ Nurse  
\_\_\_\_\_ Doctor (M/F)  
\_\_\_\_\_ Books/pamphlets  
\_\_\_\_\_ Domestic help  
\_\_\_\_\_ Neighbors  
\_\_\_\_\_ Other

## DATA COLLECTION SHEET

A- Concerns about body integrity and comfort

a. Have you had any problems with:

b. How are you coping ?

1. change in appetite
2. weight decrease
3. weight increase
4. temperature elevation
5. urination
6. bowel elimination
7. fatigue
8. legs aching or swelling
9. wound (incision) problems
10. vaginal discharge or bleeding
11. general aches and pains
12. breathing
13. dizziness
14. hot flashes
15. night sweats
16. sleeping

TOTAL

### Coping Actions

Data  
Point

Other concerns and comments related to body integrity and comfort and coping resources.  
Key: 1) not a problem 2)mild problem 3)moderate problem 4)severe problem

## DATA COLLECTION SHEET

B-Concerns about self-concept and the future

a. Have you had any problems with:

**Coping Actions**

b. How are you coping ?

Data  
Point

1. losing your femininity
2. aging more rapidly
3. starting menopause early
4. losing your health
5. not having menstrual periods
6. not being able to have children
7. gaining weight
8. regaining sexual desire
9. satisfying your sexual partner
10. partner's reaction to you sexually

TOTAL

Other concerns and comments related to self-concept and the future; coping resources.

Key: 1) not a problem    2) mild problem    3) moderate problem    4) severe problem

### Coping Actions

b.How are you coping ?

Data  
Point

1. irritability
2. nervousness
3. ability to concentrate
4. crying
5. impatience
6. unusual sadness
7. feelings of emptiness
8. feelings of hostility or anger
9. feelings of guilt
10. lack of purposeful activity
11. feelings of depression
12. feeling anxious about sex
13. feeling fragile

TOTAL.

Other concerns and comments related to emotions and feelings: coping resources.

Key: 1) not a problem    2)mild problem    3)moderate problem    4)severe problem

## DATA COLLECTION SHEET

D- Concerns about fulfilling customary roles and activities

a. Have you had any problems with resuming:

**Coping Actions**

b. How are you coping ?

Data

Point

1. cleaning your home
2. cooking
3. washing and ironing
4. doing dishes
5. driving
6. shopping
7. social activities
8. sports or exercise
9. mother's duties with children
10. your job
11. sexual activities
12. personal hygiene
13. climbing stairs
14. lifting

TOTAL

Other concerns and comments related to resuming roles and activities; coping resources.

Key: 1) not a problem    2) mild problem    3) moderate problem    4) severe problem



Section B

## CODING SHEET

A- Concerns about body integrity and comfort

	Coping Actions					
	Data* Point	IN	DA	IA	IP	S
1. change in appetite						
2. weight decrease						
3. weight increase						
4. temperature elevation						
5. urination						
6. bowel elimination						
7. fatigue						
8. legs aching or swelling						
9. wound (incision) problems						
10. vaginal discharge or bleeding						
11. general aches and pains						
12. breathing						
13. dizziness						
14. hot flashes						
15. night sweats						
16. sleeping						

TOTAL

Other concerns and comments related to body integrity and comfort; coping resources.

Key: IN-information; DA-direct action; IA-inhibition of action; IP-intrapsychic process; S-support.

\* Score on Likert Scale

## CODING SHEET

B-Concerns about self-concept and the future

## Coping Actions

	Data* Point	IN	DA	IA	IP	S
1. losing your femininity						
2. aging more rapidly						
3. starting menopause early						
4. losing your health						
5. not having menstrual periods						
6. not being able to have children						
7. gaining weight						
8. regaining sexual desire						
9. satisfying your sexual partner						
10. partner's reaction to you sexually						
TOTAL						

Other concerns and comments related to self-concept and the future; coping resources.

Key: IN-information; DA-direct action; IA-inhibition of action; IP-intrapsychic process; S-support.  
 \* Score on Likert Scale

## CODING SHEET

C-Concerns about emotions and feelings

	Data*	Coping Actions				
		IN	DA	IA	IP	S
1. irritability						
2. nervousness						
3. ability to concentrate						
4. crying						
5. impatience						
6. unusual sadness						
7. feelings of emptiness						
8. feelings of hostility or anger						
9. feelings of guilt						
10. lack of purposeful activity						
11. feelings of depression						
12. feeling anxious about sex						
13. feeling fragile						

TOTAL

Other concerns and comments related to emotions and feelings; coping resources.

Key: IN-information; DA-direct action; IA-inhibition of action; IP-intrapsychic process; S-support.  
 \* Score on Likert Scale

## CODING SHEET

D- Concerns about fulfilling customary roles and activities

	Data* Point	Coping Actions				
		IN	DA	IA	IP	S
1. cleaning your home						
2. cooking						
3. washing and ironing						
4. doing dishes						
5. driving						
6. shopping						
7. social activities						
8. sports or exercise						
9. mother's duties with children						
10. your job						
11. sexual activities						
12. personal hygiene						
13. climbing stairs						
14. lifting						
TOTAL						

Other concerns and comments related to emotions and feelings; coping resources.

Key: IN-information; DA-direct action; IA-inhibition of action; IP-intrapsychic process; S-support.  
 \* Score on Likert Scale

**Appendix C**Explanation Form for Hysterectomy Patients

Dear, Ms \_\_\_\_\_, my name is Patricia Harkins and I am a registered nurse completing my Master of Nursing Degree at Memorial University of Newfoundland.

I am conducting a study of women who have had hysterectomies. I am interested in women during the first four weeks after discharge. I want to learn about their problems and worries, how they handled them, and what help was available to them.

Your participation in this study would involve one visit by me in your home three to four weeks after discharge. I would interview you about problems and worries you have had since leaving the hospital. The interview would take approximately an hour.

I would also need to obtain information about you and your surgery from your chart in the hospital.

The information gained from this study will assist nurses to prepare patients for discharge after hysterectomy. All information collected will be confidential and I will be the only one who knows your name. The interview form used when interviewing you will have a number and cannot be connected to your name. All information will be destroyed after the study. The written results of information collected will be published in my thesis.

Participation in this study is entirely voluntary. If

at any time you wish to withdraw from the study you may do so. You may refuse to answer any questions you choose. There is no risk in participating in this study except to give time for the interview.

You personally will not benefit from the study but it will help other women in the future. You may however, request feedback on the study. A summary of the findings from the study will be available to you upon request. A copy of the completed thesis will also be available at Memorial University Health Science Library.

If you have further questions or concerns I can be reached at 722-6437.

Thank you.

If you are willing to participate in the study please sign below.

Name \_\_\_\_\_ Phone \_\_\_\_\_

**Appendix D**Consent To Participate In Bio-Medical Research

**TITLE:** A study of immediate postdischarge concerns and coping of benign posthysterectomy patients.

**INVESTIGATOR:** Patricia K. Harkins

You have been asked to participate in a research study. Participation in this study is entirely voluntary. You may decide not to participate or may withdraw from the study at any time. Your hospital treatment will not be affected by your decision to participate or not participate in this study.

Confidentiality of information concerning participants will be maintained by the investigator. The investigator will be available during the study at all times should you have any problems or questions about the study.

**INFORMATION SECTION:****Purpose of Study**

1. To identify and describe concerns of women who have undergone a benign hysterectomy at home after hospital discharge.
2. To identify the actions women used to cope with these concerns at home.
3. To identify concerns women were unable to cope with at home.
4. To identify coping resources available to women at home after hysterectomy.

**Description of Procedures and Tests**

You will be required to provide demographic data and answers to a questionnaire about your hysterectomy.

**Duration of Subjects Participation**

Three weeks after hysterectomy you will be interviewed in your home. It is estimated that it will take approximately one hour to answer items on the questionnaire.

Foreseeable Risks, Discomforts, or Inconvenience

Participation in this study involves no foreseeable risks. One hour of your time is needed to complete the questionnaire. You may refuse to answer any questions, particularly those that may cause discomfort because of their personal nature.

Benefits Which the Subjects May Receive

You will benefit from the opportunity to verbalize your concerns and thoughts about your hysterectomy experience. A copy of the study results is available upon request.

Other Relevant Information

A brief synopsis of the results will be available to the participants upon request.

I, \_\_\_\_\_, the undersigned, agree to participate in the research study described above. Any questions have been answered and I understand what is involved in the study. I realize that participation is voluntary and that there is no guarantee that I will benefit from my involvement. I acknowledge that a copy of this form has been offered to me.

\_\_\_\_\_  
(Signature of Participant)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Witness, Optional)

To Be Signed By the Investigator

To the best of my ability I have explained to the subject the nature of this research study. I have invited questions and provided answers. I believe that the subject fully understands the implication and voluntary nature of the study.

\_\_\_\_\_  
(Signature of Investigator)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Phone Number)



**Appendix E**Letter to Director of Nursing

Dear Director

As a graduate student at Memorial University School of Nursing, I am conducting a descriptive, exploratory study of immediate postdischarge concerns and coping actions of benign posthysterectomy patients. This study is for my thesis in partial fulfillment for the degree of Master in Nursing.

I am requesting permission to visit patients, who meet criteria for my sample, while they are recovering after hysterectomy in the gynecological unit of your hospital. While visiting patients I would ask for their participation in my study. If they agree they would be requested to sign a consent form.

The actual data collection will take place in the woman's home after discharge from hospital. I would appreciate if I could ask the nurse in the preadmission clinic to give hysterectomy patients a copy of the explanation of the study. I would also need to check with nurses on the gynecologic unit when patients agreeing to participate in the study are admitted and discharged.

I have enclosed for your information copies of the proposal, explanation form for hysterectomy patients, consent form for hysterectomy patients, and Memorial University Human

Investigation Committee of the Faculty of Medicine document indicating acceptance of study. Should you require further information I can be contacted at 722-6437 (home) or 778-3556 (work).

When study is completed a copy of the thesis will be available in Memorial University Health Science Library. I would also be willing to share my results with the nurses in the gynecology unit.

Sincerely,

Patricia K. Harkins R.N., B.S.N.

**Appendix F****Instructions for Gynecology Patients  
Who Have Had Major Surgery**

1. When discharged from hospital make an appointment with me or your family doctor in six to eight weeks for a checkup.
2. You will not get complete recovery from your operation until two (2) months, you should feel perfectly well by then; if you do not you should visit your family doctor.
3. You may do light housework when discharged from hospital, but rest when you feel tired. NO heavy work for 6 weeks- 2 months.
4. Use a mild laxative to avoid constipation if you have to e.g. Magnalax.
5. You should go up and down the stairs before discharge from the hospital.
6. You can take a tub bath whenever you want.
7. You may go for a walk or a drive whenever you want.
8. You may drive your car in one- two weeks depending on how you are feeling.
9. Any discharge you may have after surgery should clear up within six (6) weeks. If it persists, you should see your doctor. Do not douche.
10. The operation you had was\_\_\_\_\_.
11. You will/will not menstruate (have your monthly period) again.
12. It is possible/impossible for you to become pregnant.
13. Please check with your doctor regarding when you may resume sexual activities.
14. Resume yearly pap smear or as directed by physician.

Note. From the Salvation Army Grace General Hospital,  
St. John's Newfoundland. Reprinted by permission.





