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Exploring Postsurgical Decision Attitudes Among Young Women Electing Hysterectomy

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Abstract

Exploring Postsurgical Decision Attitudes Among Young Women Electing Hysterectomy

by

Mary Esther Webb-Tafoya

MA, Webster University, 2006

BS, Park University, 2004

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Psychology

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May 2021

Abstract

Over half a million women undergo a hysterectomy procedure for reproductive issues each year. For over a decade, researchers have explored the impact of a hysterectomy on women over age 35 with a diagnosis of malignancy. Much less is known on the impact of an elected hysterectomy over alternative treatments for younger women with benign reproductive issues. The purpose of this study was to understand women's postsurgical attitude towards an elected hysterectomy. A qualitative phenomenological design was used with purposive sampling to interview 15 women between 18-40 years of age who had a hysterectomy for a benign reproductive issue using a social media forum. The research questions were answered by examining women's postsurgical experiences through a structured interview performed live online. Emerging themes about sexual desire, arousal, climax, satisfaction, perceptions of womanhood, femininity, motherhood, healthcare professional communications, and attitude about decision were extracted from each interview through descriptive coding and validated with member checking. The results indicated that the majority of women experienced a positive attitude towards their decision to elect a hysterectomy based on their perceived sexual functioning and satisfaction; ideas of womanhood to include motherhood and femininity, and their trust in presurgical information from healthcare professionals, or other women. This research is significant to healthcare professionals and women contemplating a hysterectomy for a benign condition. The results of this study could positively impact social change on women's healthcare practices for patient and physician communications, informed decision-making of alternative treatments and postsurgical implications.

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Dedication

This work is dedicated to my parents and my children: Raul and Luz Romero, Mitchell, Brandon, and Sydney. Thank you for supporting me unconditionally and without question as I pursued this dream and goal of finishing my studies and mastering my profession to the best of my ability. There were so many family events, holidays and countless hours lost and never to be regained. Thank you for understanding the madness of this dream. You have my love and appreciation. God, I thank you for giving me the fortitude to move forward. I give you all the glory. In you, I find my identity. You have every failure God, and you will have every victory.

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Chapter 1: Introduction to the Study

Introduction

A hysterectomy is the second most common non obstetric surgical procedure conducted, averaging over 600,000 procedures annually (The American College of Obstetrics and Gynecologists [ACOG], 2017; Askew & Zam, 2013; Danesh et al., 2015). Since 2001, the number of procedures has significantly increased from 8% to 24% annually (ACOG, 2017). In 2011, that number markedly quadrupled, particularly for benign reproductive issues (Mikhail et al., 2015). The reasons for using hysterectomy as a treatment for benign reproductive issues is unknown; however, the increase in hysterectomy procedures conducted over the past 10 years for the prevention of malignant diagnoses has led to permanent, negative, and irreversible physiological and psychological symptoms (Ilknur et al., 2016). A hysterectomy is generally indicated for a malignancy, whereas it is considered elective for the treatment of benign conditions (Chou et al., 2006). How a hysterectomy has affected women's lives, the reasons for electing a hysterectomy, and the long-term effects of hysterectomy are all areas of research interest. This research project explored how a hysterectomy affected young women's self-perceptions of womanhood and sexual functioning and postsurgical experiences about their decision after physician recommendation.

Women between the ages of 19 and 60 have often received recommendations for elective and medically necessary hysterectomy. This research included women who had experienced a partial, total, or total with bilateral salpingectomy and oophorectomy, which is defined in the operational definitions portion of Chapter 2. Pynnä et al. (2014)

asserted that one out of every three women in the United States will have a hysterectomy by the age of 60. This is alarming considering the average age for premenopausal symptoms are the late 30s, with the onset of natural occurring menopause ending between ages 46-59 (WHO, 2009). According to Chou et al. (2006), more than 80% of hysterectomies performed were to alleviate severe symptoms for benign reproductive issues. More women are being subjected to premature menopause, due to total hysterectomy with bilateral oophorectomy; however, the reasons for electing hysterectomy before alternative treatments are unclear. Other treatments for benign issues exist but are often not discussed or explored due to the rate of recurrent symptoms and benign conditions such as fibroids, heavy bleeding and cysts (Karp et al., 2015). Women may elect hysterectomy to avoid or stop recurrent symptoms but are unfamiliar with the risks of future physical or psychological problems.

According to Chrisler et al. (2014), women who underwent a hysterectomy experienced negative self-perception of femininity with depression, and anxiety associated with progressive sexual dysfunction. Psychosocial factors affected by sexual decline and quality of life during naturally occurring or surgically induced menopause may not only be due to hormonal changes but can be attributed to women's negotiation of cultural constructs on sex, aging and femininity (Ussher et al., 2015). This is extremely pertinent in understanding how a hysterectomy has psychological implications on women's self-views. Older women who experienced the natural progression of menopause had more coping strategies and acceptance of the transition than younger women who underwent a hysterectomy but were still sexually active and family planning

(Topatan & Yildiz, 2012). Therefore, it is necessary to explore the physiological and psychological impact a hysterectomy has on younger women of childbearing years.

Aside from the psychological impact a hysterectomy can have on women, it is equally important to understand the physiological implications the surgery has by understanding the biological components of the female reproductive system using the normal human sexual cycle of desire, excitement (arousal), and orgasm and the effect it has on women's psychological views of femininity and womanhood. The biological structures of the female reproductive system play an important role in sexual satisfaction, perceptions of femininity, and sexuality for women of any age, as most women associate their womanhood with the ability to bear children and having healthy sexual organs (Danesh et al., 2015). Previous research regarding the effects of hysterectomy on sexual functioning have focused primarily on the impact it has had on older women entering natural menopause or women who underwent hysterectomy for malignant reproductive issues (e.g., Danesh et al., 2015; Topatan & Yildiz, 2012; Ussher et al., 2015) and less emphasis on understanding how it affects young women with benign reproductive issues, who may experience disruptions in sexuality and fertility. Women over the age of 50 reported less frequency and desire for sexual activity due to postmenopausal discomfort, such as vaginal pain from dryness, and dissatisfaction associated with inability to climax during coital penetration (Thomas et al., 2015). Women under the age of 50 reported a higher level of desire to maintain sexual relations with their partners and attributed their overall lesser quality of life and satisfaction to a significant reduction in physical desire, excitement, and ability to orgasm (Thomas et al., 2015). Women under the age of 40,

who had a total hysterectomy or total hysterectomy with bilateral oophorectomy and salpingectomy, reported less desire for sexual activity, but women who had the same surgery and reported a higher level of satisfaction and desire indicated it was due to an absence of physical pain (Danesh et al., 2015).

Factors which influence women's postsurgical experiences can lead to positive or negative attitudes about having a hysterectomy. The probability of women experiencing decision regret depended on personal knowledge and physician communication about postsurgical physiological and psychological symptoms, prior to electing the procedure (Chou et al., 2006). Women reported that had they known the long-term implications and were offered alternative therapies and treatments to address benign health issues, they most likely would not have opted for surgery, unless preventative measures were necessary (Topatan & Yildiz, 2012). Distress of embodied and sexual changes are difficult for women of any age to cope with; however, previous research on femininity and menopause indicates that younger women subjected to premature menopause experience more than just the distress of the biological event, but also the distress on relations with intimate partners (Ussher et al., 2015). The idea that pain associated with benign issues such as polycystic ovarian syndrome (PCOS), dysmenorrhea, uterine fibroids and heavy menstrual bleeding can be eliminated by gynecological surgery drives medical recommendations and elective surgery; however, some physicians have failed to educate patients on the post-implications of a hysterectomy and postsurgical treatments for possible emotional and sexual dysfunctions. Some women experienced a positive attitude towards having a hysterectomy due to the absence of pain but encountered other

negative experiences with sexual dysfunction (Thomas et al., 2015). The need for sexual education on possible outcomes for women undergoing hysterectomy can better prepare them for postsurgical expectations and changes in physiological and psychological health, improving overall quality of life.

Background of the Study

The female reproductive system represents procreation and the source of femininity in womanhood (Hinchliff et al., 2009). The uterus plays a vital role in the physiological functions of sexuality, pregnancy, childbirth, attractiveness, and perceived "beauty" of the female sex (Danesh et al., 2015). Women are often stereotyped according to their sexuality, fertility, and social status (Chrisler et al., 2014). Therefore, the natural occurrence and cycle of age-related sexual functioning and menstruation have a significant meaning in the social representation of the female role.

When females reach midlife and begin to exhibit the symptoms often associated with menopause and sexual decline, it is a widely accepted life stage and transition by both women and men. Women struggle with the negotiation of the changes in sexual embodiment associated with menopause both physically and psychologically; however, it is an anticipated life transition woman can prepare and approach with a positive coping attitude (Ussher et al., 2015). When women are subjected to premature or surgical menopause from a double oophorectomy, the psychological and physiological effects are compounding on the quality of life, particularly in self-perceptions of sexuality and womanhood, because it occurs before the natural age expected. Menopausal women often experience physiological symptoms such as hot flashes, night sweats, mood swings, sleep

disturbances, vaginal dryness, loss of libido, shorter menstrual cycles which eventually dissipate, and possibly depressive or anxiety issues due to hormonal changes (ACOG, 2017). The same symptoms occur postsurgical, when the ovaries are removed, and the body no longer produces estrogen and all receptor sites have been depleted. The ovaries are responsible for the release, regulation and formation of hormones and eggs for fertilization; therefore, the removal of ovaries in a double oophorectomy, would deeply affect the associations women make with fertility.

Ussher et al. (2015) asserted that women's negotiation of menopause is based on their appraisal of cultural and social constructs in regard to sex and femininity; therefore, if it occurs during childbearing years, the impact on life satisfaction may be negatively affected. Women anticipate during menopause that sexual satisfaction may change and accept that conceiving children is no longer an option in older age. Although some research reported that sexual functioning improved for some women, it also undermined the notion that sexual atrophy and decay are caused by menopausal symptoms due to hormonal changes and structural changes in the anatomy (Ussher et al., 2015). However, sexual decline can occur with the removal of the ovaries due to decreased hormone production, and removal of the cervix based on the structural role it plays in vaginal penetration during intercourse. The cervix plays a vital role in secretion and lubrication of the vagina during arousal, as well as increasing pleasurable sensations for coital penetration from thrusting for both male and female partner (Levin, 2005). The removal of the cervix shortens the vagina and reduces the sexual sensations and quality of orgasm for both partners. Removal of the uterus and cervix also reduces the ability for women to

achieve uterine orgasm (Levin, 2005). Since women reported that sexual functioning is correlated with social constructs of femininity and individual self-perceptions of womanhood, which includes sexuality, femininity, and ability to procreate (Chrisler et al., 2014), having any form of hysterectomy could lead to debilitating psychological effects on a woman's self-esteem and confidence.

More than 60% of the hysterectomies performed are for benign reproductive issues such as dysmenorrhea, heavy bleeding, PCOS, or uterine fibroids (Mikhail et al., 2015). None of which are life threatening or malignant in nature. Research on PCOS demonstrated that although it does have an impact on fertility, hormonal regulation, and can reduce sexual pleasure and comfort, pharmacological treatments have been effective in reversing and reducing the size and overall growth of cysts in conjunction with surgical removal of existing cysts (Carvajal et al., 2013). Medical technology is still not adequate for screening or predicting ovarian malignancy or cervical carcinomas, and the prognosis is a 45%, 5-year overall rate of survival; therefore, the driving and motivating physician recommendation for elective hysterectomy as a means of prevention is not highly reliable (Mikhail et al., 2015). It is unknown whether women who have birthed children are more likely to elect a hysterectomy to reduce risk and symptoms of benign medical issues than women without children. Past studies suggested women who had at least one child, even more than two, still expressed worry from no longer being able to have children (Gercek et al., 2016). The impact of elective hysterectomy and presurgical menopause on women of childbearing years versus women in natural menopause, past childbearing capabilities has not been explored. Because the uterus represents beauty,

attractiveness and power that a hysterectomy removes; women are left to perceive loss of youth, femininity, sexual identity and health, yielding feelings of weakness, fear of physical unattractiveness, and depression if the uterus is removed (Bayram & Beji, 2010). Malacrida and Boulton (2012) reported there was a significant correlation women hold between heteronormative sexuality, femininity, and constructs of motherhood, which did not take into account or factor the irreversible impact electing for hysterectomy has on the psychosocial implications of motherhood.

The factors used in medical recommendation of hysterectomy for benign gynecological conditions include short-term, long-term symptom relief, and long-term risk analysis for malignancy without compelling positive tests, cost effectiveness or other treatment modality considerations, which remains under researched (Pynnä et al., 2014). Whether or not physicians exercise adequate time explaining all symptomology associated with gynecological medical conditions to include pre- or postsurgical expectations of a hysterectomy is unknown. According to Lafata et al. (2016), physicians spent an average of 23 minutes with patients in a routine or specialized appointment, including preventative health communication. If patients brought a reminder list and prompted the facilitated communication, visits are at a minimum 10 minutes in length and maximum 27 minutes in length (Lafata et al., 2016). Increasing the communication between physicians and patients on preventative care or on progression of illness and how it affects the quality of life is essential and detrimental on health decision making processes (Hughes & Lewinson, 2015). Therefore, understanding what kind of

communication and information women received prior to electing hysterectomy could directly or indirectly impact their postsurgical attitude regarding their decision.

There is a significant gap in the literature about alternative treatment procedures versus hysterectomy procedures. There is limited knowledge about the long-term implications and outcomes of alternative treatments versus the experiences after hysterectomy. This study explored one aspect of this significant gap by presenting the existing phenomenon of women whose experiences post hysterectomy deeply impacted their quality of life in two areas of functioning, which influenced their attitudes towards their decision, post hysterectomy. It opens the discussion for further research on prevention and alternative treatment options before electing a hysterectomy. This study shed light on a significant problem which exists in women's healthcare and demonstrated the importance for change towards decreasing healthcare costs, improving physician communications and increasing women's overall well-being and quality of life.

Statement of the Problem

Over 600,000 hysterectomy procedures are performed annually and more than 90% of the procedures are conducted for benign reproductive issues (Chow et al. 2020). More physicians are recommending a hysterectomy to young women between the ages of 18 and 40 for benign reproductive issues which has long term implications that affects their postsurgical attitude about their decision. Young women affected negatively by decreased sexual functioning and negative self-perceptions of womanhood experience higher levels of decision regret, post hysterectomy. On the other hand, women unaffected or improved in areas of sexual functioning, and no change in self-perceptions of

womanhood, did not experience similar levels of regret. The problem with physicians recommending any type of hysterectomy to young women, between the ages of 18-40, without exploring other options, is physicians are not discussing the short- and long-term implications that any type of hysterectomy procedure will have on normal sexual functioning, loss of fertility, self-perceptions of femininity and associations women have with their sexual organs, on overall well-being, and quality of life. Women who elected for surgery and based their decision for hysterectomy on physician recommendation for the permanent relief of benign gynecological conditions could have possibly been treated with more long-term and less invasive methods. Some methods of treatment are hormone replacement, cryoablation therapy, oral contraceptives, anti-androgens, and insulin-sensitizing agents (Owusu-Ansah, 2006). Although alternative treatments to hysterectomy may be accompanied by varied side effects, women would benefit from understanding all various approaches to treatments with their respective outcomes to make an informed decision, preventing or reducing potential negative postsurgical experiences. More women can potentially experience positive attitudes about their decision to elect a hysterectomy with positive presurgical experiences.

The Purpose of the Study

The purpose of this study was to explore the lived experiences of women who were impacted by a healthcare phenomenon of physician recommendation for premature hysterectomy as a treatment to benign reproductive health issues. This study increases awareness around the psychosocial impact a hysterectomy has on women's overall well-

being and the influence presurgical consultations they received regarding short- and long-term implications had on their decision to elect a hysterectomy.

A qualitative analysis was conducted on young women's lived experiences with sexual functioning, self-perceptions of womanhood, and postsurgical attitude toward their decision to elect a hysterectomy after physician recommendation. This study explored all experiences using thematic analysis on young women who have undergone a subtotal, total, or total hysterectomy with bilateral salpingectomy and oophorectomy.

Research Questions

The central research question of this study was: What are the lived experiences of sexual functioning and perceptions of womanhood for young women who elected a hysterectomy? Answering this question was discovered by exploring and analyzing post hysterectomy experiences of sexual functioning and self-perceptions of womanhood, in young women ages 18-40 had that differed from expectations and physician explanations. In order to access these perspectives, a qualitative phenomenological method was used. Creswell (2014) asserted that the phenomenological method relies solely on personal experiences allowing the researcher to capture subjective information.

This study investigated the experiences women had pre- and post hysterectomy. Postsurgical attitudes on their decision were explored using qualitative questions on presurgical communication, self-perceptions of womanhood, and sexual functioning.

The following sub-questions were used to support the main research question:

Subquestion 1: What changes in sexual functioning do young women, ages 19 to40, experience after a hysterectomy?

Subquestion 2: How do young women who elected a hysterectomy describe their perception of motherhood?

Subquestion 3: What type of information did women receive about a hysterectomy prior to undergoing the surgery?

Subquestion 4: Among young women who have had a hysterectomy, what is their postsurgical experience regarding their decision?

Conceptual Framework

Developed by Ronald Rogers (1983), the protection and motivation theory (PMT) is used as the framework and guide to understand the participants' reasons for electing hysterectomy, based on physician recommendation. Using information presented by physicians to participants regarding threat of possible malignancy and recurrence of symptoms and pain, PMT allowed me to demonstrate how threat and coping appraisals affected women's decision to elect for hysterectomy without considering alternative treatments. In addition, application of PMT allowed me to analyze the experiences of short- and long-term implications of the surgery on their sexual functioning and self-perceptions of womanhood. This theory is an extension of the health belief model (HBM), developed by U.S. Public Health Services, social psychologists, Godfrey Hochbaum, Irwin Rosenstock, and Stephen Kegels (Rosenstock, 1974) used to predict public attitudes and actions towards health issues based on a number of constructs which measure what causes or persuades people to behave more health consciously. Robinson's (2015) sexual health model (SHM) was used to explain how participants' responses, from a semistructured interview developed for this study, describe how a hysterectomy

impacted their sexual functioning and self-perceptions of womanhood. SHM explores the physical and psychological components posited to be essential to healthy human sexuality (Robinson et al., 2002). These models are further discussed in Chapter 2.

The PMT is an extension of the HBM, which focuses on the intention to self-protect as the proximal determinant of health behavior based on three components of fear appraisal: (a) Magnitude of noxiousness of a depicted event, (b) probability of that event's occurrence, and (c) efficacy of a protective response (Rogers, 1983). Gynecological conditions may not be preventable since compelling evidence suggests that precursors, hereditary, genetics and existing screenings cannot predict that any one woman may experience any issues in her lifetime (van der Meij & Emanuel, 2016). Therefore, the components of the HBM would not be useful in exploring and understanding the subjective experiences of the participants considering that the premise of that model is built on several constructs regarding perceived susceptibility, threat, and cues to action regarding changing health behavior. Using PMT, women confronted with gynecological conditions weigh perception of threat against coping efficacy to elicit intention towards changed health behavior.

Rogers (1983) described threat as susceptibility or vulnerability to perceived health issue and severity as perceived seriousness of acquiring the health threat, which would motivate protective behavior. If physicians insinuate that a benign condition could possibly turn into a malignancy, are women perceiving that malignancy is imminent, inevitable and therefore elect for surgery as a preventative measure? There are no

accurate screenings available that can predict malignancy or suggest a benign condition can potentially become a severe fatal health risk (Pynnä et al., 2014).

In response to threat, Rogers (1983) postulated that individuals then assessed self-perceptions of coping efficacy based on response efficacy, proposed protective behavior to avert threat, self-efficacy, and the individual's perceived ability to perform coping response. Taking into account physician's explanations proposed solution for hysterectomy versus alternative treatments, if mentioned, women based their decision to elect for hysterectomy with the expectation of long-term, permanent elimination of pain and symptoms as opposed to long-term management of pain and recurrence (Pynnä et al., 2014). Each woman's assimilation of threat and coping efficacy drove intention to follow through on physician recommendation and follow through with behavior.

With SHM, Robinson et al. (2002) define healthy human sexuality in 10 key essential components, which encompasses culture and sexual identity, sexual anatomy and functioning, body image, and intimacy in relationships. This was an important concept used to investigate if any form of hysterectomy had such an impact on anatomical structures responsible for arousal that were irreparable, affecting participant's postsurgical experience; and the impact culture, intimacy, relationships, and sexual functioning had on body image and sexual identity. Insights gained as a result of this study could be used as guidance for presurgical education regarding postoperative expectations of sexual functioning, and sexual health care.

I took a phenomenological approach, which explored each individual's perspective and subjective experience with how any form of hysterectomy had impacted

individual self-perceptions of womanhood and sexual functioning. Pearce et al. (2014) explored individual experiences of surgical menopause and how each participants' life was impacted. The study demonstrated that a group of women, who had undergone the same surgical process but were not associated, had common and similar experiences (Pearce et al., 2014). Common themes were identified across individual responses, to demonstrate if all women in the study had experienced similar symptoms, postoperative.

Coding was used to identify common themes and associations women made in reference to womanhood. The information gathered demonstrates common experiences and self-perceptions of femininity, sexuality, psychological, and physical responsiveness to sexual intimacy, which is discussed further in Chapter 2. Basic questions on the quality of preoperative physician visits were explored to identify type of professional consultation women obtained, and the quality of information and education they received regarding the postoperative expectations of a hysterectomy.

Rogers' PMT (1983) is the theoretical framework, while Robinson's (2015) SHM is the conceptual framework. PMT provided the theory for individual decision-making on health issues required to understand the intention and motivation behind electing hysterectomy for the treatment of benign gynecological conditions. Whereas SHM provided the conceptual framework in explaining and understanding the essential aspects of human sexuality which affected normal functioning.

Nature of the Study

The nature of this study is a qualitative method, using a phenomenological approach to understand women's lived experiences post hysterectomy. Understanding

women's self-perception of sexual functioning, womanhood and postsurgical experiences regarding their decision assisted the researcher in gaining a deeper understanding of the impact a hysterectomy had on women's lives. Exploring women's pre- and postsurgical experiences with healthcare professionals provided a clearer understanding of the thoughts and feelings women have which affected their ability to make well informed decisions about their health. The wealth of information gained from the in-depth interviews with women uncovered vital information about how significant the trust and confidence are that women place on physician recommendations. This is information, which has not been previously explored or studied, may be invaluable to healthcare professionals in obstetrics and gynecology.

Phenomenological studies use sampling strategies to identify participants who share a common phenomenon. The qualitative method of exploration on common themes and context of subjective experiences prohibited researcher bias by demonstrating similarities of consistency in experiences across participants, type of surgery, and postoperative timeframe. Since this study relied heavily on individual experiences to demonstrate similarities across participants, qualitative inquiry was the most effective approach towards conducting research in an individual's natural environment (Creswell, 2008). According to Moustakas (1994), the combination of qualitative inquiry and phenomenological approach provides the most unbiased, informed, and detailed source of information. One of the focuses of this study was to understand the impact a hysterectomy had on the sexual functioning and self-perceptions of womanhood in young childbearing women and if presurgical education on postsurgical expectations would

have changed their decision to elect for surgery. Perceptions evolve from subjective individual experiences; thus, accessing such experiences through semistructured interviews offers the best opportunity to understand if women's postsurgical experiences and attitudes about their decision is associated with their physician's recommendation to elect for hysterectomy.

The study focused on women between the ages of 18-40 who elected any type of hysterectomy for a benign reproductive issue per physician recommendation. Recruiting participants was conducted by posting flyers in physician's offices. This included obstetrics and gynecology (OB/GYN), primary care physicians (PCPC), family practitioners, endocrinology, and psychiatry. The flyer included my phone number and email to contact for the informed consent inclusion questionnaire.

The study included 15 young women, ages 18 – 40, who had any type of hysterectomy for a benign gynecological issue and experienced changes in sexual functioning and self-perceptions of womanhood. The data included in this study explored the changes in sexual functioning to include desire, arousal, ability to have an orgasm and sexual satisfaction. The data discussed in this study explored women's self-perceptual changes on their ability to have more children and how that may have affected their connection with their partner and altered their perceptions of being less feminine or sexual. The data was gathered from semistructured interviews. Interviews were conducted and recorded using Zoom (real-time videoconferencing). The phenomenological data analysis method was used to identify and analyze common themes in the responses.

The study did not include women who had a hysterectomy for a malignant health issue or women experiencing natural menopause. Women from various educational, socioeconomic status, race, ethnicity and marital status were also included. The results and description of participants is explained in Chapter 4. Strategies for coping with post hysterectomy symptoms was not the focus of this study; therefore, this study did not offer or include treatment-based outcomes.

The study did not include any participants who were unwilling to be video recorded. By recording participants, I was able to review interviews for thorough analysis. The study does not contain any quantifiable evidence on sexual functioning; rather, it is intended to qualify the participants' subjective lived experience and identify common themes across experiences to demonstrate a real phenomenon worthy of future research and exploration. It was not the focus of this study to rate level of severity of each participant's experiences on sexual dysfunction or the self-beliefs of womanhood were. The purpose of this study was to provide an in depth understanding of participant perceptions. Quantifiable measurements on sexual functioning were not used to explore an objective viewpoint because it did not support a qualitative phenomenological inquiry.

Finally, no assessments, measurements or inquiries were conducted on participant and physician interaction because the data required was not on the amount of time or quality of visit, but on lack of information, which could not be reproduced postsurgical. This study identified common themes across participants' experiences on whether or not they were informed that their post hysterectomy symptoms were possible prior to their surgery. Identified common themes across participants' experiences demonstrated that

the lack of information women perceive was shared prior to surgery, happened frequently. This was a significant aspect of this study which helped to explain what influenced women's post hysterectomy attitudes about their decision. Pakbaz et al. (2017) found that women often received limited information prior to gynecological surgery due to lack of knowledge on what to ask, lack of preparation for the appointment, and holding physician recommendation in high confidence.

Operational Definitions

Hysterectomy: Gynecological surgery resulting in the removal of the uterus, preventing pregnancy (ACOG, 2017)

Partial hysterectomy: Gynecological surgery which can be performed laparoscopically or abdominally resulting in the removal of the upper part of the uterus and leaving the cervix intact (ACOG, 2017).

Protection and Motivation Theory: Theory originally created to clarify fear appeals and the factors we use to protect ourselves from illness and disease (Rogers, 1983).

Sexual Functioning: Five factors of sexual ability to include desire, arousal, orgasm, pain, and sexual satisfaction (Danesh et al., 2015).

Sexual Health Model: A theoretical model, which incorporates the importance of adapting all education for sexuality in accordance with the unique needs, desires, experiences, and norms of a target population (Robinson, 2015).

Total hysterectomy: Gynecological surgery with the removal of the cervix and the entire uterus (ACOG, 2017).

Total hysterectomy with bilateral salpingectomy and oophorectomy: Gynecological surgery resulting in the complete removal of the cervix, uterus, both ovaries and the fallopian tubes (ACOG, 2017)

Womanhood: The state of being a woman, which includes femininity, sexuality, motherhood and cultural perceptions.

Assumptions

Assumptions are preconceived notions, which may often be unnoticed but inadvertently influence or affect the current study. Using a phenomenological approach suggests that there are basic assumptions that humans are self-interpreting social beings and can best describe a phenomenon through their living subjective experiences, as well as through individual description (Wertz et al., 2011). There is an assumption that young women, of childbearing years, who have had a hysterectomy, have experienced similar symptoms in sexual functioning and self-perceptions of womanhood.

There were several assumptions made about participants' understanding. First, I assumed that all women, who participated in this study, understood the normal progression of aging in relation to sexuality, reproductive cycle, and the stages of menopause., I assumed they knew the difference between benign and malignant gynecological issues and the long-term implications of the treatments they chose. Thirdly, I assumed that their doctors advised all women who had experienced benign issues that a hysterectomy was the best option for the relief of symptoms, recurrence and prevention of malignancy. I also assumed that the women in this study were less informed of alternative medications and treatments for benign gynecological issues and

placed trust and confidence in physician recommendations. Likewise, I assumed that their responses to the assessments were a true reflection of the physiological and psychological distress a hysterectomy procedure has had on the quality of their life. Next, I assumed that the participants had changes in attitudes towards their choice of a hysterectomy rather than alternative treatments and believed that with presurgical education about their post hysterectomy experience, their decision for elective surgery would have been different. Last, it was assumed that common themes would emerge from participant responses. If common themes were not identified, further questioning would have been conducted for phenomenological analysis.

Scope and Delimitations

The scope of this study focused primarily on only three aspects of post hysterectomy experiences which included sexual functioning, perceptions of womanhood, and postsurgical attitudes toward decision to elect surgery. Other areas of research related to hysterectomy and women revealed other psychosocial problems which exist such as health related conditions, impact on interpersonal relationships with intimate partners, surgical experience, psychological functioning, and partner perceptions of the procedure which this research did not address. I took a personal interest in the topic of this study based on professional experiences as a counselor, having worked with women who reported decision regret after a hysterectomy due to reduced libido, sexual dysfunctions, and negative of self-perceptions as a woman. I also had a personal interest in the topic being a woman who had a hysterectomy at a young age for benign issues and experienced decision regret.

The sample population in this study was limited because it was not randomly chosen. The study included 15 women specifically chosen for their age, type of hysterectomy, diagnosis of a benign reproductive issue, and expressed changes in sexual functioning and self-perceptions of womanhood post hysterectomy. Sexual preference was also a limitation as all participants were heterosexual women and it is unknown if women with other sexualities are equally affected by a hysterectomy.

Limitations

Qualitative research can provide a deeper understanding of a phenomenon providing insight and awareness through in-depth interviews of participants' experiences; however, some limitations to this approach requires the researcher to be thoughtful and specific about their objectives (Anderson, 2010). The willingness of participants to share their experiences does not account for the other aspects of participants' life experiences including personality, mental status, number of children women had, possible miscarriages or abortions, or lack of desire to have children, which may have posed a limitation. How participants communicate their perceptions and how data is interpreted was a limitation because there is a limitation to individual introspection, communication style, expression, openness about sexuality, bias, and willingness to share all aspects and factors to be explored. Although I shared a common experience, this was not disclosed to reduce the possibility of effecting participant responses. Not all participants shared similar experiences; therefore, I sought similar consistent themes. The qualitative approach allowed me to develop follow-up questions to gain further clarification and description of participant experiences (Anderson, 2010). Last, there was a limitation in

the amount of time since participants had their hysterectomy; therefore, different participants were at different timeframes or stages postsurgery and recollection of experiences may not have been clear.

A consistent concern for qualitative studies is credibility and reliability requiring researchers to ensure collected data was done rigorously and without bias. This can be done with the use of triangulation which requires researchers to use two or more methods to investigate the phenomenon of the study or to use participant validation of their responses by reviewing their responses to ensure accuracy of interpretation (Anderson, 2010). Participant validation was used to eliminate any personal biases in the interpretation of participant responses.

Significance of the Study

There was a significant gap in available literature on attitudes following the decision to have a hysterectomy for benign reproductive issues in women ages 18-40. In addition, there was a gap in understanding the effects that surgery had on their quality of life in relation to sexual functioning and self-perceptions of womanhood. Accessing individual lived experiences, post hysterectomy, provided new insights into the need to provide women with presurgical education on postsurgical symptoms and effects. Presurgical information can influence women's attitudes after post hysterectomy (Bayram & Beji, 2010). This research explored the experiences of women's postsurgical attitudes on their decision providing an element of realism and awareness, which can only be achieved through a qualitative, phenomenological approach. This research offers new perspectives and opportunities for health care professionals and women alike to

reestablish presurgical awareness, informed care, women's health care initiatives, and reduced healthcare costs.

Significance to Practice

This research lends to future solution-oriented and preventative initiatives to be developed for women who experience benign reproductive issues and encourage healthcare professionals to explore women's health concerns associated with short- and long-term implications of a hysterectomy. By doing this, the number of hysterectomy procedures conducted for benign issues can decline offering women more options for alternative treatment and improve the psychosocial impact a hysterectomy has on women's postsurgical experiences and attitudes about their decision to elect for surgery. Empowering women with adequate knowledge and lived experiences of other women, as part of their decision-making process can improve postsurgical experiences. Reducing the number of hysterectomy procedures conducted annually could reduce overall healthcare costs and unnecessary medical procedures with long-term implications that can decrease quality of life and increase healthcare risks. This research provides in-depth exploration of women's lived experiences often not gained from presurgical or postsurgical clinical visits with healthcare professionals. Women rarely discuss important aspects of postsurgical expectations prior to a hysterectomy, simply for lack of knowledge that their physical or emotional well-being could be negatively affected (Bayram & Beji, 2010; Pearce et al., 2014).

Significance to Theory

The PMT is a theoretical model used to explain the thought process and coping approach individual's take towards decision-making and action on health issues (Rogers, 1983). Robinson's SHM is a conceptual framework which opens research to understanding the motivation behind health-related decisions and the need to overcome the challenges of stigmas associated with talking about sexual health, functioning and behavior (Robinson et al., 2002). When individuals make health related decisions, such as surgical procedures, on partial information, by not asking questions about sexual health for fear of embarrassment or cultural stigmas, likelihood for decision regret increases. This study introduces further researchable inquiries to the physiological and psychological differences of sexual functioning and perceptions of womanhood, post hysterectomy.

Significance to Social Change

This study has the potential to highlight the importance of presurgical counseling for any life-altering surgery, particularly for hysterectomy, since it identifies areas of negative psychosocial impact is on women. This study also exemplifies how social change can be promoted through informed care to reduce healthcare costs and surgical decision regret. The insights gained from this study highlights the importance of the holistic approach to health care and address ways to address the gaps between patient and healthcare professionals. Such social change could have a positive effect in regard to women's health care issues and treatments.

Summary

Hysterectomy is the second leading most common surgery, for women, after C-sections, and there are a number of other physiological and psychological implications, which follow, up to 10 years postoperative (Topatan & Yildiz, 2012). Up to 600,000 hysterectomies are performed yearly and the number of benign reproductive issues women suffer from continues to rise significantly as well (Mikhail et al., 2015), which calls for alternative approaches to treatment other than permanent surgical removal of women's reproductive organs. However, with current treatments for benign issues, symptoms are recurrent and may worsen over time, which cause women to elect for hysterectomy to gain permanent relief from symptoms (Lethaby, Mukhopadhyay, & Naik, 2012). There is an insurmountable amount of research on the correlation between hysterectomy, surgical menopause, hormones, and other illnesses; however, this study focused only on the correlation of hysterectomy on sexual functioning and perceptions of womanhood in women who are young, sexually active and family planning. The current study attempted to address the gap in knowledge by conducting a qualitative phenomenological inquiry on how women's decisions to elect for hysterectomy may have been influenced had they known how the surgery would affect their sexual functioning and self-perceptions of womanhood. By accessing these individual perspectives of women who have experienced negative postoperative effects, new insights can be gained to improve pre surgical counseling.

Studying the individual perspectives of women trying to live with postoperative symptoms, offered an opportunity to gather new insights for future hysterectomy

protocol. Utilizing the insights gained from the PMT, and SHM illuminated the factors which influenced women's decisions to elect for hysterectomy and demonstrated missing information from informed health decision making. Applying the tenets of both theories in a qualitative phenomenological approach offered the best opportunity to understand the psychosocial factors, which contributed to women's decision to have a hysterectomy, such as culture, perceptions of sexuality, femininity, motherhood, and sexual satisfaction.

A current literature review on the correlations between hysterectomies, benign and malignant reproductive issues, hormonal consequences, surgical menopause, sexual functioning, femininity, and culture is offered in Chapter 2. The review offers a discussion on the impact hysterectomies have had on women of all ages, natural menopause versus surgical menopause, and the psychosocial impact it has on women's self-perceptions of femininity, sexuality, and sexual functioning. The use of and rationale for a qualitative methodology and phenomenological approach is discussed in Chapter 3, along with research design explanation. Study results, interpretations of findings and future recommendations are discussed in Chapters 4 and 5.

Chapter 2: Literature Review

Introduction

The first section of this qualitative method literature review explains the constructs of this research. The second section examines the theoretical base of how hysterectomy procedures affect sexual functioning and self-perceptions of womanhood, including postsurgical attitudes about the decision to elect a hysterectomy. The third section of this literature review explores the qualitative conceptual framework of negative post hysterectomy effects on sexual functioning, self-perceptions of womanhood, postsurgical attitudes on decision, and what is lacking in presurgical communication. This research claims a basic assumption that presurgical communication between women and their physicians is lacking a clear understanding of posthysterectomy impacts on sexual functioning and perceptions of womanhood towards informed decision making to elect surgery. There is abundant research on hysterectomy for malignant and benign reproductive issues and the impact on sexual functioning, to include societal perceptions of femininity, across a wide range of ages and cultures. However, there is a significant gap in the research regarding women's decision regret on electing hysterectomy for benign reproduction issues during childbearing years because of how the procedure has affected sexual functioning and self-perceptions of womanhood. This research explores the experiences some women have had and offers a solution to augment deficient presurgical communication. The fourth section of this literature review will examine the need to increase the quality of presurgical physician and patient consultations regarding posthysterectomy implications.

Literary Search Strategies

Literature was obtained using an online search with PsyARTICLES, MEDLINE, PsycINFO, CINAHL, Cochrane Library, Nursing databases, and medical websites that focused on women's health issues, hysterectomy, menopause, sexual functioning and quality of life. There was limited recent research available on hysterectomy and sexual functioning, and limited research on childbearing women's experiences with hysterectomy. Literature published from 2000 to present was reviewed, excluding theoretical research. Key search terms were *hysterectomy, body image, femininity, sexual functioning, menopause, womanhood, decision regret, sexual desire in women, sexual arousal in women, women and childbirth, intimacy, surgical menopause, bilateral oophorectomy, perimenopause, post hysterectomy, quality of life, protection motivation theory, sexual health model,* and *perception of female role.* Literature was filtered to peer-reviewed journals, medical websites, and books. Any literature used prior to that date was referencing the theoretical frameworks used and refutable evidence to demonstrate limitations and areas for further research. Any references used from 2014 or prior to were taken from credible peer-reviewed sources on research that has been unduplicated, updated, or re-explored. Other resources would be secondary references such as textbooks or original works by the authors of theories used in this study, or relevant works to support or dispute.

History

A hysterectomy is the surgical removal of a woman's uterus in parts or whole. Hysterectomies have been performed since the 19th century and were more frequently

performed throughout the 20th century (Mettler et al., 2010). This research includes women who have had any type of hysterectomy procedure. Each type of hysterectomy will be explained with supporting research of how each procedure has affected sexual functioning and perceptions of femininity. The types of hysterectomy procedures include subtotal, total, and total with bilateral salpingectomy and oophorectomy. Each procedure varies in which portion of the reproductive organs are removed, which may have differing physical and psychological effects on women's functioning.

Subtotal Hysterectomy

A subtotal hysterectomy, often referred to as a partial or supracervical hysterectomy, is the removal of the upper portion of the uterus, leaving the cervix intact. A supracervical hysterectomy was offered as an alternative to a total hysterectomy for benign conditions, sparing uterine nerve damage, bladder injury and urinary incontinence (Meston, 2004). With just the upper portion of the uterus removed, pregnancy is no longer an option; however, the ovaries are still intact, leaving other options for childbearing such as surrogacy. Contradictory research exists suggesting that some women who underwent a supracervical procedure for benign conditions reported improved sexual functioning in areas of desire and orgasm, whereas, in other research women reported a decrease (Meston, 2004). Some research debated the psychological and physiological symptoms of a hysterectomy, implying that changes in sexual functioning post hysterectomypost hysterectomy may not be solely attributed to physical changes, but rather psychological. Sexual functioning may have improved due to the absence of prehysterectomy symptoms such as heavy bleeding, cramps, and painful

intercourse. Women may feel more in control of their lives and more sexual in absence of symptoms. Rannestad et al. (2001) explored supracervical hysterectomy's effects on pelvic pain, urinary friction, bowel function, weight, menopause, psychological well-being, sexual function, fatigue, insomnia and self-perception of femininity, in women of varying ages between pre to postsurgical symptoms and revealed that percentages ranged significantly across all variables. In the same study, supracervical hysterectomy, depending on whether it was performed abdominally, vaginally or laparoscopically, also affected how women perceived their sexuality and self-concept in regard to body image and sensuality (Rannestad et al., 2001). Whether or not the procedure is done abdominally, laparoscopically, or vaginally can affect post hysterectomy symptoms such as uterine or bladder prolapse, healing time, and scarring. Abdominal procedures require cutting through several layers of abdominal muscles and the pelvic wall, increasing healing time and recovery. Some women reported with the extended healing time and damage to abdominal muscles, including scaring, and pelvic floor distension, and that they felt less attractive and more self-conscious with sexual partners (Rannestad et al., 2001). A vaginal procedure requires entry through the cervix and removal of the uterus in whole with ligaments (Mettler et al., 2010). With a vaginal procedure, there are risks of bladder prolapse, incomplete cervical closure if the cervix is not removed, damage to vaginal walls, pelvic floor, and urinary incontinence (Pakbaz et al., 2017).

The discipline of gynecology was founded in 1813 when the first vaginal hysterectomy was performed, laying the foundation for vaginal procedure as the least invasive, cost effective and time efficient method, which can be performed in six to ten

steps (Mettler et al., 2010). However, the use of laparoscopic procedure remains the safest most effective approach when leaving the cervix intact. Laparoscopic procedures include the fastest healing time and less injury to the bowels, bladder, uterine ligaments and abdominal walls, and pelvic floor (Mettler et al., 2010). Understanding the impact of each type of procedure should be part of the presurgical consultation physicians engage in with women to aid in their decision for electing hysterectomy.

Total Hysterectomy

A total hysterectomy is the removal of the whole uterus and the cervix. Indication for a total hysterectomy is often recommended in cases of malignancy or cervical carcinomas and abnormal cell growth. However, in cases of benign conditions, there are no indications for removal of the cervix. The cervix directly connects the vagina with the uterine lumen and is responsible for the secretion of the vasodilator neuropeptide, vasoactive intestinal peptide (VSP), which relaxes genital smooth muscle for arousal, engorgement and lubrication (Levin, 2005). Clearly the removal of the uterus would affect reproduction, but removal of the cervix would greatly affect sexual functioning. Meston (2004) ascertained that a supracervical hysterectomy might have negative effects on orgasmic ability, indicating that uterine contractions are necessary for orgasm. The absence of the cervix affects the contractions known as uterine up suck from posterior pelvic floor distention (vaginal tenting) that occurs to facilitate conception and increase penile penetration during coitus (Levin, 2005). With removal of the uterus and cervix, many of the natural contractions and arousal abilities are lost. Meston (2004) indicated that a total hysterectomy affected the pelvic autonomic nerves because the uterus is

separated from the cardinal and uterosacral ligaments, which are responsible for the genital vibrations of arousal and coital penetration. However, some research indicated some women reported arousal and orgasmic vibrations improved post hysterectomy, as well as subjective feelings of sexual attractiveness devoid of the pre hysterectomy symptoms (Rannestad et al., 2001). Some women reported that in absence of symptoms, psychologically, they were no longer self-conscious or aware of the challenges to sexual desire, arousal or intercourse (Levin, 2005). Previous research has demonstrated equal subjective claims of positive and negative self-perceptions of femininity post hysterectomy. This suggests there might be a difference between the physiological and psychological impact on women in regard to the removal of any portion of the reproductive system.

Total Hysterectomy with Bilateral Salpingectomy and Oophorectomy

A total hysterectomy with bilateral salpingectomy and oophorectomy (BSO) is the removal of the whole uterus, cervix, fallopian tubes, and ovaries. This is the most invasive procedure and indications for this surgery would be for uterine, cervical, or ovarian carcinomas, or severe endometrial cell growth that is malignant in nature (Mettler et al., 2010). Therefore, this type of procedure for benign conditions subjects women to severe post hysterectomy changes, which can increase risk for other health issues such as bladder prolapse, vaginal dryness, pelvic floor weakness, loss of vaginal elasticity (vaginal atrophy), low genital arousal, inability to achieve orgasm and complete inability to conceive or be impregnated. Karp et al. (2015) identified that a BSO in premenopausal women increased risks for cardiovascular disease, diabetes, cognitive disorders, carotid

thickening, sexual and mood dysfunctions due to hormonal decline. Physicians often consider the practice of BSO for benign issues in premenopausal women with familial history of breast and ovarian cancer, although there is no evidence or positive tests in some candidates (Pynnä et al., 2014). In most cases, a total hysterectomy with BSO is performed abdominally or laparoscopically. Expected healing time for such an invasive surgery could vary but is typically six months for full recovery and includes sexual abstinence. The increase in health risks should be discussed with women prior to electing for a hysterectomy with BSO for benign issues. A Swedish study on the impact of hysterectomy in women for benign issues indicated that all candidates reported not being aware of post hysterectomy risks, symptoms or effects, and attributed that to insufficient physician patient communication or feeling extremely overwhelmed with information that they could not recall (Pakbaz et al., 2017).

Based on an analysis of all the literature it is evident that each type of hysterectomy, despite procedure, will have a psychological or physiological impact on women depending on their lifestyle, expectations, and age. This research particularly focuses on women of childbearing years who are sexually active, with or without a partner, and have future expectations to bear children. To fully understand how sexual functioning is affected, the physiological and psychological factors of sexual functioning are explained on the normal human sexual cycle.

Sexual Functioning in Women

This research defines the following factors related to sexual functioning in women to be desire, arousal, orgasm and sexual satisfaction. Women's reduced sexual

functioning post hysterectomy is used as one of the contributors to decision regret. Earlier research demonstrated the effects of menopause on sexual functioning, indicating that low estrogen impacts sexual desire, arousal, and physiological functions of arousal such as vaginal lubrication and inability to achieve climax (Chedraui et al., 2009). Women who have had hysterectomy with BSO are more likely to experience these symptoms; however, some women post supracervical or total hysterectomy reported decreased libido, vaginal sensation, ability to achieve orgasm, loss in sensation of penile penetration, and painful intercourse due to shortened vagina (Danesh et al., 2015). It is unclear which factors contributed to increase or decrease in sexual functioning; therefore, the criteria of sexual dysfunctions, according to the DSM-5, will be used as a basis for understanding if women's experiences meet diagnostic criteria or a postsurgical effect. Physiological symptoms may have a direct impact on sexual functioning just as equally as changes in psychological functioning, absent the symptoms, may affect sexual behavior. Nevertheless, previous research does indicate that women nearing natural menopause are better candidates for hysterectomy considering postsurgical reports of 40-50% women experience other social, physical and psychological symptoms such as urinary system injuries, bowel perforations, constipation, insomnia, fatigue, weight changes, crying spells and depression (Bayram & Beji, 2010). This research explores the effects a hysterectomy has on women of childbearing years, ages 19-36, and the impact it has on their sexual behaviors. How hysterectomy effects sexual functioning can prove to be useful in the presurgical counseling and discussion women have with healthcare professionals, before electing the surgery.

Desire

Sexual desire is comprised of physical and psychological responses to sexual intimacy. Desire may also be linked to physical and mental health often affected by certain psychosocial factors such as age, comorbid conditions, medication, pelvic organ surgery, perimenopause and menopause (Lermann, Häberle, Merk, Henglein, Beckman, Mueller, & Mehlhorn, 2013). Sexual desire in healthy women is related to the psychological desires of sexual activity, self-image embodiment, and estradiol and testosterone levels. According to Lermann et al. (2013), hypoactive sexual disorder would be the absence of desire for sexual activity and may not occur simply because of a hysterectomy, regardless of procedure; however, it may be caused by a combination of physical and psychological factors. A woman who has received a subtotal hysterectomy may not experience a dramatic change to the pelvic organ structure, keeping the same vaginal length, cervix in situ, and ovaries intact; therefore, sexual desire may not be affected but self-perceptions of womanhood in regard to childbearing may be impacted. A woman receiving a total hysterectomy may be impacted in both areas this study focuses on, with removal of the uterus, shortening of the vagina and removal of the cervix; however, there is refutable evidence that it does not affect sexual desire.

Arousal

Sexual arousal follows sexual desire and is triggered by psychological and physical responses within the body. Arousal is elicited by desire, reciprocal reinforcing cognitive and physiological systems to a sexual stimulus, which triggers neurocognitive reactions from past experiences and biological responses from hormones and

neurotransmitters (Chivers & Brotto, 2017). Meston (2004) attributed the decline in sexual arousal, post hysterectomy, to damage on the pelvic autonomic nerves and impaired vasoconstriction response to erotic stimulation. However, in the same research, Meston (2004) identified that those women who reported positive outcomes were based on relief of symptoms to benign indications such as uterine fibroids, fibrocystic ovarian pain and dysmenorrhea. A woman who has undergone a subtotal hysterectomy may not experience a loss in sexual arousal or desire simply because of minimal change to the pelvic organs and the ovaries and cervix remaining intact. A total hysterectomy may adversely affect arousal on a psychological level if intercourse becomes painful due to vaginal dryness, shortening of the vagina and reduced vascularity to the organ by removal of the cervix (Meston, 2004). Vasoactive intestinal peptide (VIP) is a vasodilator neuropeptide stored in vipergic nerves of the cervix, which is the second highest area of concentration compared to the vagina, and induces genital engorgement and vaginal lubrication (Levin, 2005). A total hysterectomy with BSO would cause the same effect. Additionally, removal of the ovaries would cause a decline in estradiol, which adversely affects libido. Women that have undergone a total hysterectomy with BSO also experience a higher risk and susceptibility to PH imbalance and vaginal infections since cervical secretions such as VIP are high in anti-inflammatory Type 2 cytokines, which maintain balanced vaginal flora and fauna during and after coitus (Levin, 2005). With decreased sexual desire and arousal, likelihood of achieving orgasm reduces. Understanding the physiological and psychological components of orgasm increases understanding of how hysterectomy affects a woman's ability to achieve climax.

***Female Sexual Interest and Arousal Disorder*.** Previously termed hypoactive sexual desire disorder, female sexual interest and arousal disorder (FSIAD) is now combined in the DSM-5. The disorder defines desire and arousal as a coexisting problem indicated by reduced frequency or interest in sexual activity and pleasure and the nature. Diagnostic criteria for the disorder are met if the individual presents 3 of the following symptoms with significantly reduced or lack of sexual interest and/or arousal:

1. Absent/reduced interest in sexual activity.
2. Absent/reduced sexual or erotic thoughts and/or fantasies.
3. Absence of or reduced initiation towards sexual activity to include reduced responsiveness to partner's initiations.
4. Absent or reduced sexual excitement or pleasure during sexual activity in 75%-100% of sexual encounters, whether context is situational or generalized.
5. Absent or reduced sexual interest or arousal in response to sexual cues internal or external (e.g., written, verbal, and visual).
6. Absent/reduced genital or non-genital sensations during sexual activity, approximately in 75%-100% of all encounters, in any or all contexts (APA, 2013).

In addition to meeting at least three of the aforementioned criteria, according to the DSM-5 (APA, 2013), symptoms must have persisted for six months, caused significant distress in the individual, and not otherwise be explained by a nonsexual mental disorder, consequence of severe relationship distress, substance/medication, or medical condition. After diagnosing this disorder, it must be specified if it was a lifelong

or acquired condition; if it occurs across all contexts of sexual functioning or situational, and level of severity. Previous research on the comparison of hypoactive sexual desire disorder (HSDD) across the different hysterectomy types, concluded that not all women experienced reduced sexual desire, arousal or orgasm but that common loss of sensation due to the removal of the cervix, uterus and ovaries negatively impacted the feedback system in the brain in regard to intensity of sexual sensation (Lermann et al., 2013). In the same study, compared alongside previous studies on women who have had any form of hysterectomy and HSDD, there was a prevalence of diagnosis between 23%-37% (Lermann et al., 2013). According to the DSM-5 (APA, 2013), prevalence, development and course of sexual desire/arousal decline is often associated with age meaning there is a normative decline across the lifespan. However, this research focused on women of childbearing years, who underwent a hysterectomy for benign causes, and experienced premature sexual decline, causing distress and reducing quality of life. Some women may or may not have experienced reduced sexual desire and arousal; however, may have experienced reduced sexual sensation to reach climax or intensity of orgasm.

Orgasm

Orgasm is achieved from sexual stimulation and contraction of the uterine and vaginal muscles. Saini, Kuczynski, Gretz, & Sills (2002) asserted that the ability to achieve orgasm depended on the stimulation of the nerve endings in the uterovaginal Frankenhauser plexus surrounding the cervix, which increases pleasurable sensation. A woman who has undergone a subtotal hysterectomy may not experience any dramatic changes or ability to achieve orgasm and can increase sexual stimulation during coitus

from clitoral manipulation. However, a woman who has undergone a total hysterectomy or total hysterectomy with BSO could experience significant changes in ability to orgasm or sustain pleasurable sensations during intercourse, with or without clitoral stimulation. Despite psychological arousal or stimulus to engage in sexual activity, or physiological responses, a woman may still not be able to achieve orgasm from penile penetration, in absence of clitoral stimulation, caused by the removal of cervical nerve receptor sites. Decreased arousal, desire and inability to achieve orgasm experiences will be explore in the participant's interview on perception of sexual functioning.

Female Orgasmic Disorder

The DSM-5 (APA, 2013) characterized female orgasmic disorder (FOD) as the absence of or reduced orgasmic sensations, which persists for a minimum duration of six months causing the individual significant distress and cannot be better explained by a nonsexual mental disorder, consequence of relationship distress, substance/medication, or medical condition. The diagnosis also requires specification regarding how it was acquired, nature of occurrence and level of severity. According to the diagnostic manual, reported cases of FOD ranges from 10%-42% due to factors such as age, culture, previous experience of orgasm, duration and symptom duration; however, menopausal women are not consistently associated with orgasm difficulties (APA, 2013). This excerpt may exclude women from this diagnosis without further research or understanding in the role of the uterus and cervix during orgasm. Levin (2005) reported that women who normally experienced an inner orgasm, often referred to as a uterine orgasm, might be impacted more by a total hysterectomy with or without bilateral

oophorectomy, simply because it would affect the contact between penile thrusting not commonly associated with clitoral orgasm. Within the same research, it was stated that without a basis for comparison between women pre- and post hysterectomy, a valid supported conclusion could not be made; however, a comparison between women with a radical total hysterectomy, which includes bilateral salpingectomy, oophorectomy, with removal of lymph nodes and supporting ligaments against a subtotal hysterectomy, reported lower levels of desire and arousal from vaginal denervation (Levin, 2005).

Satisfaction

Establishing the factors which contribute to sexual satisfaction and how it affected overall sexual functioning and self-perceptions of womanhood was determined using the Female Sexual Function Index (FSFI) questionnaire. The FSFI is a brief questionnaire that assesses various domains of sexual functioning such as sexual arousal, orgasm, satisfaction and pain (Rosen, Brown, Heiman, Leiblum, Meston, Shabsigh, Ferguson, & D'Agostino, 2000). The questionnaire was developed for the purposes of assessing domains of sexual functioning but does not replace a clinical evaluation, or explore sexual experiences, attitudes, knowledge or interpersonal functioning (Rosen et al., 2000). The domains of the FSFI were used to define sexual functioning and women's subjective experiences with the phases of sexual functioning. Satisfaction would also be inclusive of women's interpersonal relationships with intimate partners; however, this was minimally important, as some of the participants for this research were single without a partner. Sexual satisfaction was based on ability to become aroused physiologically and psychologically; desire to have sex, feeling desirable, and achieving

orgasm during sex. Some research indicated that women associated a decrease in sexual satisfaction with the loss of cervical stimulation, decreased pelvic congestion, decreased ability to achieve orgasm from loss of cervix and uterus in addition to the psychological representation of the removed uterus (Bayram & Beji, 2010). Women who have undergone a subtotal hysterectomy may experience minimal changes in sexual functioning; thus, minimal changes in level of satisfaction. In previous research, women reported little to no physical changes in overall sexual satisfaction from subtotal procedure; however, being aware they could not conceive reduced sexual interest (Bayram & Beji, 2010). Women who have undergone a total hysterectomy and total with BSO reported differing levels of sexual satisfaction. Absence of presurgical symptoms led to greater satisfaction in some cases, whereas, in other cases it adversely affected desire, arousal, orgasm and psychological disinterest in sex.

Womanhood

The factors that define womanhood are important to consider when discussing post hysterectomy regret. Hinchliff et al. (2009) described women's associations with womanhood to be all the factors that contributed to sexual ability such as sense of self, self as a lover, sexual attractiveness, and sexual embodiment. This research explores four areas of social perceptions on women: Femininity, sexuality, motherhood, and female gender role. How society views women versus how women view themselves affected how women internalized the impact a hysterectomy had on their self-concept. Trying to negotiate society's cultural expectations of heterosexual women created fear of judgment, fear of comparison to healthy sexual women, and challenges in interacting with other

women on topics of pleasurable sex, intimacy and relationships (Hinchliff et al., 2009). The conceptualization of womanhood has been researched and otherwise defined in previous studies. Uko (2014) asserted that the conceptualization of womanhood is defined by a woman's sexuality: Sexual awareness, status, capacity, and potential to bear children, in regard to biological and social dimensions. Societal views on women also encompassed a woman's feminine role in a relationship, including motherhood. There tends to be a behavioral norm for both men and women which implies that women lose their status as "real" women when they choose not to reproduce or demonstrate maternal skills or qualities that uphold social gender roles and expectations (Bosson & Vandello, 2013). Each facet of womanhood will be explained as it pertains the perceptions and experiences of the participants.

Femininity

Femininity, by definition, refers to the qualities, nature and characteristics of the female sex (Merriam-Webster, 2003). Femininity is presumed to be the direct opposite of masculinity, deeply embedded in the personality, and rooted in biological sex (LaFrance, 2017). For this research, femininity is defined as a single construct, which holds stereotypical qualities of the female sex related to sensuality of the female body, anatomical structures of the female body, and female role in a heterosexual relationship. How women are affected psychologically and physiologically, after a hysterectomy was explored. With the removal of any or all the reproductive organ structures, do women feel less like a woman? Wong and Arumugam (2012) recognized that younger women

experienced more psychological distress from loss of the uterus and being subjected to early menopause than older women.

Sexuality

Sexuality in this research is defined by women's sexual awareness, sexual embodiment, sexual desire, ability to engage in sexual activity, and sexual gratification. Uko (2014) observed the role of women in relationships and marriage, asserting that women held a significant role in their ability to meet the sexual needs of their partners and to have the ability to respond positively to sexual activity and pleasure. This study proposes that women who are unaffected in their self-perceptions as being sensual and sexual beings hold more positive attitudes regarding their decision to elect hysterectomy; whereas women who have negative self-perceptions of sexuality experience a negative attitude towards their decision.

Motherhood

Cultural context may shape attitudes toward women's sexuality; however, people generally report benevolent attitudes towards traditional ideologies of women as housewives, and mothers as opposed to non-traditional roles such as feminists, sexual aggressiveness or frigidity (Chrisler et al., 2014). Not all women chose to become mothers; however, the option to conceive and bear children is a privilege most women possess. In a study of 43 women, ages 18-31, $n = 21$ childless women reported they considered *motherhood* a rite of passage to femininity and sexuality as true embodiment of womanhood (Malacrida & Boulton, 2012). When examining a woman's decision to elect a hysterectomy during childbearing years, it is important to consider those women

who have chosen to delay childbearing past 25 and the steady decline towards infertility. Longitudinal studies demonstrated that between the years 1971 to 2013, women were choosing to delay having children up to 30 years of age (Kearney & White, 2016). The population of interest for this study was within the childbearing ages of 18-40 providing a clearer understanding of the impact it had on women's family planning choices.

Theoretical Framework

Protection Motivation Theory (PMT)

Protection Motivation and Threat Communication Interactions

Understanding personal motivation for health decisions is a subjective experience, which cannot be easily observed. Rogers (1983) posited that health behavioral change was elicited by individual perceived threat and vulnerability to illness along with perceived self-efficacy to respond to the threat. If health decisions were based on perception of risk, barriers or challenges, and perceived benefits to change for preventative health problems than Rosenstock's (1974)) HBM would be sufficient to understand the motivation behind women's decision to elect for hysterectomy. If preventative health decisions were based solely on stages and individual readiness for change then a transtheoretical approach with decisional balance (Prochaska, Redding & Evers, 2002) would be sufficient to explain the process of decision making in electing for hysterectomy. However, since perception of illness is the basis for change, then it is necessary to understand and assess subjective perceptions when it comes to electing for surgery; therefore, Rogers' (1983) cognitive and physiological processes of fear appeals, and attitude change was used for this research. Women electing hysterectomy for benign issues fear negative effects on their

sexual functioning and intimacy with partners (Danesh et al., 2015); however, despite the negative risks, they still elect the surgery. The impact hysterectomy has on sexual functioning is not the only postsurgical symptom women must assess and consider since some research indicates that a hysterectomy may have other general health and psychological implications (Bayram & Beji, 2010). Any form of hysterectomy would have a direct impact on fertility and ability to bear children. How this could affect women during childbearing years that may or may not have a partner could have long term regret for an irreversible decision, which may affect overall quality of life in later years. Although there are several alternatives to having children such as adoption and surrogacy, the ability to conceive could be associated with women's perceptions of womanhood.

The purpose of this literature review is to discuss the theoretical background of the concepts which contribute to the perception of womanhood, sexual functioning on women's quality of life, how both are affected by a hysterectomy; and the relationship between presurgical communication and decision to elect hysterectomy. The SHM was used to explain how sexual functioning and womanhood affect women on several psychosocial aspects such as intimate relationships, femininity, childbirth, sexual communication, desire, arousal and satisfaction. The PMT was applied to explain how fear appraisals affect women's decisions to elect for hysterectomy when confronted with a benign reproductive issue. This research identified the relationship between posthysterectomy effects on sexual functioning, self-perceptions of womanhood and attitudes about the decision to elect surgery. Lastly, what lacked in presurgical

communication on posthysterectomy symptoms was explored, emphasizing just how influential physician recommendations are.

Rogers developed the cognitive and physiological processes of fear appeals and attitude change to demonstrate the factors of fear appraisal in the amount of information communicated, type of information conveyed, presence of other contributing sources of information, and what information is communicated which increases fear arousal (p. 157). The amount of information conveyed from the physician in regard to the physical condition could be limited or elaborated in a manner, which makes numerous references to danger or threat of severity (p. 157). According to Rogers, the use of personalized references to how the condition could worsen (threat appraisal), or impact the individual, increases the fear appraisal and physiological fear response causing the individual to associate only negative consequences, which elicits action to reduce likelihood (p.158). The emotional and physical arousal of fear is a subjective phenomenological experience that can only be measured in terms of the adaptive coping response given. Women may perceive their vulnerability and susceptibility to cancer as being high, if they do not address the benign issue; therefore, they choose the most effective approach to treatment to reduce the likelihood. In this case, women may follow physician recommendations to elect for hysterectomy when presented with the possibility that benign reproductive issues and symptoms can worsen, never subside or diminish, or possibly become malignant. Thus, electing for hysterectomy is presented as a viable long-term solution to the problem without exploring other options. Fear arousal associated with cancer, or ineffective treatments for recurrence or malignancy, can motivate women to elect for

surgery. Ineffective treatments, which may only provide temporary relief to symptoms and not resolve recurrence of symptoms, may be presented to women as being cost ineffective, expensive to maintain, and time consuming. Pynnä et al. (2014) attributed the recommendation of hysterectomy as a more cost-effective solution to benign issues when considering long-term treatment and measures to address recurrence to such disorders as heavy bleeding and fibroid cysts. Women may consider a hysterectomy to be the better solution to recurrence or other medical treatments simply based on their ability to manage pain or other physiological symptoms. Four months, postoperatively, women reported that their quality of life decreased in regard to social relationships but improved in overall physical health perhaps because they experienced symptom relief (Krishnasamy & Vaidyanathan, 2015). Women may consider this an acceptable pay off not realizing the long-term effects a hysterectomy could have on their intimate and social relationships with others. Chrisler et al. (2014) researched the impact a hysterectomy had on the female social role, stating there is a social stigma associated with women's different stages of reproductive life. Women without children who have had a hysterectomy are pitied for their inability to meet that social role of fertility and motherhood being viewed as old, irritable, cold and incompetent (Chrisler et al., 2014). How physicians present the benign condition may affect women's views of susceptibility and vulnerability to malignancy. Women may not fully understand that their perceived risk and vulnerability is based on the physician's threat appraisal. Threat appraisal becomes significantly more acute when personalized to the patient their risk for susceptibility and vulnerability. Rogers (1983) stated that threat appraisal that involves

personalized references such as “this can happen to you”, are far more compelling to elicit patient response then stating it is a possible risk.

Coping appraisal is based on the individual’s perception of self-efficacy and responsiveness to the threat (Rogers, 1983). If women are led to believe that having a hysterectomy is the best option, they can take to permanently eliminate recurrence of symptoms or possible malignancy, it’s possible they elect for surgery thinking they’ve taken the best solution and responsibility for improving their physical health and reducing risk. Other theories, such as Lazarus’ Transactional Model of Stress and Coping attempt to explain primary and secondary appraisal responses by individuals to illness and disease. According to Lazarus, primary appraisal is the individual’s assessment of the situation as threatening, or harmful which results in illness and emotional reactiveness; whereas secondary appraisal is the individual’s assessment of resources to combat the threat (Lazarus & Folkman, 1984). Lazarus also suggested that individuals may have positive strategies for coping through problem-solving and emotional regulation (Lazarus & Folkman, 1984). PMT was used for this research to demonstrate how individuals may not resort to their own ability to manage their health, but to rely solely on the professional advice and guidance of healthcare professionals.

Conceptual Framework

Sexual Health Model (SHM)

Robinson et al. (2002) developed the SHM as a holistic definition of sexual health by demonstrating there are 10 key components to the essential aspects of healthy sexual functioning: Talking about sex, sexual anatomy and functioning, culture and sexual

identity, challenges to sexual health, sexual health care and safer sex, body image, masturbation and fantasy, intimacy and relationships, positive sexuality, and spirituality. Applying the concepts behind the components of the SHM to women's lived experiences will provide the perspective held on what is considered healthy sexual functioning and basis of how Rogers' PMT explains influence and appraisal of health issues. This is further explained by defining each concept t and how it relates to this research.

Talking About Sex

According to Robinson, Munns, Weber-Main, Lowe, & Raymond (2011), individuals need to learn and practice how to openly talk about sex in an explicit and comfortable manner. This is a very important factor to consider in exploring women's experiences prior to hysterectomy in regard to the quality and comfort each woman perceived in their discussion about sexuality, sexual health, and sexual behaviors with their healthcare professional. If women are not comfortable in asking questions or discussing their own sexual health, relationships and needs, then they may not know how having a hysterectomy, or not would affect their sexual relationships. This was explored in question 1 and 7 of the questionnaire. Women will be able to express and explain whether or not they discussed sexual health, their reasoning and the impact it had on their experience and decision.

Sexual Anatomy and Functioning

Women may not be aware or familiar with all aspects of anatomy and functioning. Sexual functioning aligns with the normal human sexual cycle of desire, arousal (excitement), orgasm and resolution. Healthy sexual functioning occurs when there is

adequate knowledge and understanding of anatomy and sexual fulfillment (Robinson et al., 2011). Some conflicting research indicates anatomy is unrelated to sexual functioning and satisfaction; however, the psychological reaction to the changes in sexual anatomy may be idiosyncratic with postsurgical sexual dissatisfaction (Sözeri-Varma, Kalkan-Oguzhanoglu, Karadag, & Özdel, 2011; Goetsch, 2005).

Culture and sexual identity in regard to womanhood

Culture could be a large factor and determinant of how women relate to themselves as sexual beings and may directly or indirectly impact the first component of talking about sex. It would be important to recognize the impact culture and sexual identity has on women's attitudes, behaviors and sexual health to fully understand how this affects women's sexual satisfaction. Women often identify as being sexually inadequate in comparison to their male partners (Robinson et al., 2011). In addition, exploring how women identify within their culture as a woman and family or social construct as a woman is important in understanding perception of womanhood and motherhood.

Challenges overcoming barriers to sexual health

Some women reported severe anxiety and depression posthysterectomy which may be attributed to hormonal or physical changes which may or may not have a physical impact but possibly and psychological impact (Bayram & Beji, 2010). Therefore, it is imperative to explore the perceptions women hold on the physical and psychological impact hysterectomy has had on their sexual functioning. Co-morbid mental health disorders should be assessed and treated as they may be a major factor impacting sexual

functioning. Other factors to consider would sexual trauma, surgical trauma, and side effects of medication.

Sexual health care and safer sex

Sexual problems which existed prior to surgery or occurred postsurgical such as sexually transmitted diseases, physical pain and discomfort or medication side-effects should be addressed and considered in the impact it may have on sexual desire and arousal. Although there is conflicting research of a hysterectomy increasing or decreasing sexual functioning, some studies suggest that arousal and desire are closely related to positive or negative sexual experiences and physical functioning (Chivers & Brotto, 2017). Other evidence suggested couples fail to discuss the decision of getting a hysterectomy and how it will affect their sexual relations as most women fear losing attractiveness and the support and understanding from their partner (Bernhard, Harris, & Caroline, 1997). Sexual health care may directly or indirectly affect a woman's self-views of intimacy, sensuality, and sexual satisfaction. This aspect is explored through women's experiences of sexual satisfaction, frequency of sex and self-perceptions of sexual functioning.

Body image

Whether or not all women have experienced sexual satisfaction may be correlated to self-perceptions of femininity and womanhood in relation to sexual desire (Hinchliff et al., 2009). Posthysterectomy perceptions of womanhood may be related to women's desire to engage in sexual relations and whether or not sexual functioning is important to quality of life. Exploring women's self-perceptions of body image pre- and

posthysterectomy may be an indicator of psychological impact on sexual functioning since some research suggests that sexual functioning is not affected by the removal of reproductive organs; therefore, women's perceptions may be the only factor contributing to their positive or negative experience with having had a hysterectomy. If women still hold a positive self-image of their body posthysterectomy, they are less likely to experience decision regret than a woman who perceives she is "less" of a woman and no longer a sexual "being."

Masturbation and fantasy

Women are capable of having vaginal and clitoral orgasms which result in contractions of vaginal walls and the uterus (Brotto, 2017). Some research indicated that women can still experience an orgasm, posthysterectomy, after removal of the uterus, but at less intensity, especially if the procedure was conducted vaginally (Pfaus, Quintanna, Cionnaith, & Parada, 2016). By exploring women's attitudes and perceived sensations posthysterectomy, we can better understand if their sexual encounters have been affected positively or negatively and how this may in turn impact their feelings about the decision they made. According to Robinson et al. (2011) women who engage in sexual self-exploration, such as masturbation, are better able to communicate desires to their partners when they understand their own arousal. Therefore, women may experience negative sexual responses posthysterectomy due to perceived changes not necessarily physical in absence of other methods and approaches to sexual satisfaction.

Intimacy and relationships in regard to how current relationships have been affected

How women perceive their sexual and intimate interactions with partners prior to a hysterectomy is vital to understanding the effects and perceptions posthysterectomy. A number of factors should be considered whether they made an informed decision, asking all questions as it pertained to sexual functioning, and if they included their sexual partner in the decision process or communication regarding the procedure and postsurgical implications. A phenomenological study conducted on male partner's experiences prior to a hysterectomy had identified six common themes: 1) limited knowledge of surgical process; 2) considerations and adjustments to changes in one's sex life; 3) support in making necessary decisions; 4) difficulty in acquiring information regarding uterine disorders; 5) ensuring the wife's safety during the operation, and 6) expecting full communication with medical, founded that men who were involved and supported their wives during the process experienced positive effects of sex and intimacy (Chou et al., 2006). Evidence suggests that couples don't discuss the implications of a hysterectomy prior or after the procedure and men express concern reduced sexual ability will affect their experience and the longevity of the relationship (Askew & Zam, 2013). Some men reported wives who experienced negative self-perceptions of femininity and low libido prior to surgery remained the same posthysterectomy and were deeply affected by the inability to conceive more children (Hoga, Higashi, Sato, Bozzini, Baracat, & Manganiello, 2012). How a hysterectomy has affected sexual and intimate relationships may be a factor in women's attitude about their decision to elect for surgery.

Positive sexuality

Robinson et al. (2011) posited that woman who are empowered to discuss their sexual needs are educated in sexual differences and learn to set boundaries and expectations. This study will explore what information and experiences women had with their healthcare professionals prior to surgery and what questions and concerns they shared with physicians about posthysterectomy expectations. If women who are sexually aware and comfortable with their sexuality, then they may be more likely to discuss pertinent information regarding how a hysterectomy may impact them. They would feel more inclined to ask more in-depth questions and consider those possibilities as well as communicate with partners, involving them in decision making process.

Spirituality and religion

How women identify within their culture, gender role, and spirituality may be impacted posthysterectomy. Understanding the role spirituality plays in womanhood, sexuality, and motherhood will also explain whether or not women experience decision regret. How sexual health aligns with women's ethical, spiritual; values and moral beliefs will be explored and if they are affected by electing hysterectomy.

By applying the SHM to women's perceived experiences of sexual health and Rogers' theory of protection and motivation to perceived illness which affected health decisions we can better understand the impact a hysterectomy had in each of these areas of functioning, reasons for electing hysterectomy and whether women experienced a positive or negative attitude about their postsurgical decision. Not all women experience decision regret which may be attributed to perceived sexual health; whereas some women may experience decision regret due to negative perceptions of sexual health in one or

more of the 10 components of Robinson's SHM. Identifying common themes in participants' lived experiences provide further insight to understanding the common perceptions women with decision regret experienced and women who were unaffected experienced.

Review of Variables and Concepts

This study focuses on the four aspects of sexual functioning according to Masters and Johnson's human sexual cycle which consists of desire, arousal, orgasm and resolution (Basson, 2000). It is the most basic linear model of stage progression for sexual activity that clearly describes the phases. Levin (2008) proposed that the descriptions of each phase required revisions due to the number of scientific gains and understandings of the biological structures and functions of the sexual organs. This study will explore how women's sexual phases were affected by a hysterectomy and draw from research and other studies performed on how a hysterectomy changed the organ structures and responses. Chivers and Brotto's (2017) exploration on women's desire and arousal responsiveness revealed that the psychological responses of sexual activity are just as important as the physiological and using the Incentive Motivation Model (IMM), identified that physical and psychological are reciprocally-reinforcing. This implies that physical sexual desire and arousal may be triggered by cognitions of desire and arousal, or vice versa. This is important to this study considering the assumptions of this research were that physiological changes posthysterectomy is the culprit to sexual decline. Gaining women's subjective experiences of desire and arousal and perceptions of womanhood (being less feminine or sexual) affected their desire for sex or ability to

become aroused. Later findings suggest that sexual functioning is a psychophysiological process which may imply that sexual functioning would indeed be affected by removal of biological structures that play a role in sexual responses (Bayram & Beji, 2010; Chivers & Brotto, 2017; Meston, 2004; Pearce et al., 2014). Meston's (2004) study focused on women with fibroids and the physiological aspect of sexual arousal, posthysterectomy, by analyzing the vaginal pulse amplitude to erotic stimulation but did not assess the subjective experiences women had. This study attempts to understand women's perceptions of sexual functioning and womanhood which contributes to reduced and negative responses posthysterectomy.

Interview questions will be open-ended and followed-up by prompts to have participants provide further details and descriptions of experiences. Questions are developed to address each research question and align with each of the 10 concepts of Robinson's SHM. Prompts are effective at facilitating participants to share their experiences. This study will produce a wealth of in-depth, qualitative, and subjective data which will require rigorous analysis to identify and present what is most relevant to the objectives.

Extensive research on women posthysterectomy, using quality of life inventories, have not demonstrated any improvement in overall functioning. In several studies, researchers identified that there was zero to minimal improvement of all women in areas of sexual functioning and perceptions of femininity (Krishnasamy & Vaidyanathan, 2015; Rannestad et al., 2001; Topatan & Yildiz, 2012; Ussher et al., 2015). Most women who reported there was no change in sexual functioning typically reported level of

functioning was the same prior to surgery (Rannestad et al., 2001). All studies utilized Likert scale type questionnaires to quantify sexual satisfaction, which lacked detailed information and richness of subjective data normally gained in qualitative interviews. This study is not concerned with measuring severity of sexual functioning or quantifying perceptual experiences but explaining women's perceptions of how and what changes they experienced. Studies on femininity, motherhood and sexuality provided the basis for defining womanhood in this study. Previous researchers agree that the conceptual term womanhood best defines the complexity of how women identify their role in regard to femininity, motherhood, sexuality, and sensuality asserting that neither concept is independent of the other but rather each is a facet of the whole (Hinchliff et al., 2009; Levant, Richmond, Cook, House & Aupont,2007; Chrisler et al., 2014). This study explores women's perceptions of femininity, sexuality and motherhood and will utilize the term womanhood to encompass all these facets. Previous researchers have attempted to quantify women's perceptions using Likert type scales; however, this does not entirely capture experiences and subjective views and feelings. Chrisler et al. (2014) discovered, using the Ambivalent Sexism Inventory (ASI) that college students (n = 281) all rated benevolent scores in their attitude towards women with a hysterectomy, which implied they were pitied and incompetent because they could not become pregnant. The study failed to examine the attitudes, perceptions and feelings of the women who were categorized as menstruating, menopausal, pregnant, with a small child, and those after a hysterectomy (Chrisler et al., 2014). Several studies conducted associated womanhood with fertility and the ability to bear children, using scales which assessed childbearing

and femininity ideology attitudes on a Likert scale (Levant et al., 2007; Naidoo, 2010; Söderberg, Lundberg, Christensson, & Hildingsson, 2013). Many of the scales used in previous studies were considered; however, the ability to capture the lived experiences of the participants was the main focus of inquiry.

I chose to explore participant's posthysterectomy experiences with having the surgery and how sexual-functioning, self-perceptions of womanhood and presurgical communications with healthcare professionals may have affected them. This study assumes quality of presurgical communication was an influential factor in the final decision to elect a hysterectomy and the research interest is on postsurgical experiences and attitudes about their decision. Previous studies on patient and physician communications identified that women, dependent upon age, confidence level, trust, and rapport with healthcare professional, determined whether they were able to discuss sexual health topics (Hughes & Lewinson, 2015). Other studies identified that women placed a higher level of confidence on physician recommendations without question and posthysterectomy reported residual thoughts whether the recommendation was appropriate (Skea, Harry, Bhattacharya, Entwistle, Williams, MacLennan, & Templeton, 2004). This study is aimed towards exploring if women's presurgical communications with a healthcare professional influenced their decision to elect a hysterectomy and if their postsurgical experiences in sexual functioning and self-perceptions of womanhood affected their postsurgical attitude toward their decision to elect for surgery.

Summary and Conclusions

Common themes identified in the literature helped shape the focus of this study. This research aimed to capture lived experiences women had posthysterectomy that previous research couldn't capture using scaled assessments. I attempted to broaden interview questions to elicit more in-depth information regarding the topics of interest using previously used questions in research and drew from scaled assessments to develop open-ended questions. Using a qualitative phenomenological approach enabled me to develop prompts to facilitate participant responses that other approaches don't support. Collected data presented from this research offers a deeper understanding to the topic of this study which guides opportunities for further research.

Chapter 3: Research Method

Introduction

The purpose of study was to explore the impact a hysterectomy had on young women of childbearing years when the surgery was recommended for a benign reproductive issue. How it affected women's sexual functioning and self-perceptions influenced their postsurgical attitude towards their decision. This chapter introduces the research methodology behind this qualitative phenomenological study. This chapter explains the research design and rationale, the role of the researcher, research procedure, data collection process, how the data was analyzed, and research credibility.

Research Design and Rationale

This phenomenological inquiry was an attempt to uncover meaning, articulated by women's lived experiences posthysterectomy. Using a phenomenological approach, the focus was on common themes among women's presurgical consultations with physicians and postsurgical experiences with self-perceptions of sexual functioning and womanhood, which contributed to their attitude about their decision. Grounded theory is a systematic methodology in the social sciences field which focuses on the methodical collection and gathering of qualitative data for theoretical analysis, based on a question of interest (Creswell, 2014). Applying this perspective facilitated the method of inquiry and the phenomenological reflection of women's lived experiences post hysterectomy in comparison to their presurgical functioning. Only women can attest to their perceptions of conceiving and carrying a child or their own, sexual attitudes, behaviors and feelings.

The applicability of phenomenological theory for this study are discussed in-depth in this chapter. The research plan, including the methodology, population, sample population, procedure, analysis of data and ethical concerns were the primary components of this chapter.

Research Questions

This study sought to understand how women's lived experiences affected their postsurgical attitude about their decision to elect hysterectomy by exploring and identifying common themes among young women's perceptions of their posthysterectomy sexual functioning and self-perception a of womanhood. The central question which drove this study was:

RQ: What are the lived experiences of sexual functioning and perceptions of womanhood for young women who elected hysterectomy?

The following subquestions will be used to support the main research question:

Subquestion 1. What changes in sexual functioning do young women, ages 18 to 40, experience after a hysterectomy?

Subquestion 2. How do young women who elected hysterectomy describe their perception of motherhood?

Subquestion 3. What type of information did women receive about hysterectomy prior to undergoing surgery?

Subquestion 4. Among young women who have had a hysterectomy, what is their postsurgical experience with their decision?

Role of the Researcher

I have worked 15 years in the mental health field and hold a Bachelor of Science in Social Psychology and Master of Arts in Mental Health Counseling. None of the participants had a direct or personal relationship with me that represented a conflict of interest, such as a client relationship, reporting, personal, or professional that may have imparted bias on the research study.

I had been trained with the skills necessary to perform the designed study. I interviewed all the participants with the questionnaire she developed with the intent to identify common themes to a phenomenon. My experience and training included 13 years of counseling, therapeutic and effective listening, Socratic questioning, and motivational interviewing. Since 2006, I worked with several populations to include women's health issues in a clinical setting. For 8 years, I focused on sexual disorders and dysfunctions and working with couples on intimacy, parenting, and emotional connection. I chose the given topic of research based on personal experience and interactions with other women with similar experiences. This ignited interest in the topic to investigate and explore if there were more women who have encountered the same experience.

Methodology Selected

Phenomenology

This qualitative study was performed using interpretative phenomenological analysis theory, Modified Stevick-Colaizzi-Keen method. This method of inquiry allowed me to identify the essence of a human experience as it was discussed by participants (Creswell, 2014). Interpretive phenomenological analysis was introduced to

the research community and became a more widely used approach during the 20th century allowing researchers to use a more exploratory approach to understanding participant experiences and perceptions in a more meaningful way (Tuffour, 2017). Phenomenological approach typically follows four distinct steps: (a) bracketing, (b) intuition, (c) analysis, and (d) description (Creswell, 2014). The Modified Stevick-Colaiz-Keen method was chosen as the best approach to maintain unbiased and avoid judgment throughout the research process. There was limited previous research on young women's experiences with elective hysterectomy and the effects it had on their sexual functioning and perceptions of womanhood. Previous research had focused on positive or negative impacts of sexual desire and arousal in relation to physical responses. This study focused on the emotional and psychological aspects of what it meant to have a hysterectomy and experience changes in how a woman perceives herself as a sexual being, woman, and mother. This study sought to conceptualize the phenomenon of each participant's experience through common themes found among women's responses and if it affected their postsurgical attitude towards their decision. Interpretation of their shared experiences was analyzed by identifying common themes and content in the data from their interviews. The constructs investigated in this study are sexual functioning, womanhood, presurgical communication and postsurgical attitude towards their decision.

Bracketing

The process of bracketing is essential to phenomenological reduction, which is the process of separating common knowledge or existing knowledge of the phenomenon from what the researcher seeks to identify, using an unbiased approach (Moustakas,

1994). I sought to understand the experiences and perceptions of the participants by identifying common themes and similarities across descriptions to develop a common view. The Modified Stevick-Colaizzi-Keen method describes this as the researcher's epóche, which translates to looking at the phenomenon with fresh eyes, devoid of opinion to identify units of meaning (Moustakas, 1994). According to the approach, the researcher is permitted to disclose their experience in the beginning of the research and have the opportunity to examine their own experience so as to remain unbiased throughout the process of research.

Intuition

This stage of investigation refers to the researcher's ability to immerse in the study and the phenomenon by remaining open to the meaning it has for those who experienced it (Creswell, 2014). It was during this process that I varied line of questioning or developed follow-up questions to gather further information. The Modified Stevick-Colaizzi-Keen method best described this as transcendental-phenomenological reduction where different perspectives of the phenomenon are reviewed in segments or units of meaning then formed into themes. During this phase, I considered personal perspective to the phenomenon to develop some descriptors to construct themes. How participants described womanhood, sexual functioning and postsurgical experiences about their decision differed. Therefore, I sought to identify common descriptors among the participants' perspectives.

Analysis

This phase of analysis required that I developed themes from what participants shared that best described their experiences. Imaginative variation is the how (thematic construction) to the transcendental phenomenological reduction (the what) of the phenomenon (Moustakas, 1994). In this phase, I relied on imagination and intuition to reflect the relationship between themes and the experience (Creswell, 2008). From common descriptors of the constructs: Sexual functioning, womanhood and decision attitude, I developed a common theme to code particular references and words used in the participants' descriptions of experiences.

Description

This is the last phase of the process where I took the data and formulated a basic understanding to define and convey the phenomenon to others (Creswell, 2014). This phase is recognized and referred to as the synthesis phase where I drew from each participants disclosure a textural-structural description, which best captured the essence or represented the best meaning of their experience (Creswell, 2008). Descriptions of participants' experiences is explained in themes which best described the constructs of this study.

Sampling Population and Sampling Procedures

The sample will be drawn from a population of women who demonstrated interest to participate in the study from a flyer placed on a social media platform called Research and Me. All participants were English speaking and between the ages 18 and 40. Women were not excluded on the basis of race, ethnicity or sexual preference. Exclusions were limited to age and any history or diagnosis of malignant reproductive issues.

Participants were recruited through a social media platform, Walden's participant pool and snowball sampling. Women signed up on the social media platform, called Research and Me, on Walden's participant pool site or were referred by other participants to the link on the flyer. Women who contacted me via the email provided on the flyer were then sent the link to the inclusion questionnaire, which was also included on the flyer. The inclusion questionnaire was intended to rule out and identify qualified participants. The informed consent was placed before the inclusion questionnaire on google docs. Participants were required to consent to the questionnaire and full participation of the study prior to answering questions. Once the inclusion questionnaire was completed, I reviewed to ensure that participants met the inclusion criteria and an invitation to participate in a web-based interview was sent via email, within 24 hours. Interviews were conducted and recorded via Zoom and saved electronically on my hard drive. Consent to be recorded was also included on the informed consent. After the interview, I reviewed and transcribed the interview, and a hard copy was sent to the participant within 72 hours to review. I anticipated 15-20 participants for the study. The final analysis was conducted on 15 participants. Twenty participants were recruited in the event a participant dropped out or if participant fail to answer three or more questions in the interview. Participants were not obligated to remain in the study and could dropout at any time.

Data Collection

The study was conducted using an interviewing method found in Appendix D. I took notes to capture additional thoughts, ideas, or observations made during the

interview. Interviews were conducted and recorded via Zoom, a HIPPA compliant platform. No interviews were conducted without receipt of written informed consent or completion of the inclusion questionnaire. The interviews began with open-ended questions and prompts designed to provide more in-depth responses and elicit more subjective information from participants.

The questionnaire for participant inclusion took approximately fifteen minutes to answer and the interview approximately one hour. This provided me enough time and ability to deliver prompts and ask follow-up questions in the event the participant did not understand the question, was distracted, or strayed from responses.

Research Procedures

I obtained approval from the Institutional Review Board (IRB) from Walden University. Once approval was given, I reached out and provided local physicians with the flyer in Appendix C to be posted. I used Google Docs to build an online informed consent and questionnaire to determine patient inclusion. The link to both were offered on the research flyer. Once potential participants were screened and identified using the participant inclusion questionnaire (see Appendix D), they were invited to participate in a face-to-face interview. The study and process were included on the informed consent for participants to read. Participants could agree to study by signing the online informed consent to participate in the inclusion questionnaire. I reviewed all participant responses and if participant was selected, they were invited to participate in a face-to-face interview conducted and recorded on Zoom.

The interview was conducted via a private confirmation code and invitation at a designated time and day on Zoom. I asked each participant if there were any questions prior to engaging in the interview questions. The participant was reminded that the interview was being recorded and their interview would be transcribed within 3 days and sent to them to review for any further comments, revisions or omissions.

Phenomenological theory seeks to understand lived experiences through studying participants in an extensive engagement and developing patterns and relationships from participant responses (Moustakas, 1994). This theory emerges from the data; therefore, I used prompts during the interviews as an opportunity to gather more in-depth explanations and descriptions of participant experiences to fill gaps that emerged.

Once all interviews were completed and transcribed, each participant was given an opportunity to review their interview and retract any content. Participants were encouraged to add further thoughts after reflection. Any changes were included in the final interview transcription. All participants were thanked for their participation and provided resources in the informed consent should they need additional support. I reviewed all transcripts, adding participant reflection comments for analysis. Participants were not part of the analysis or writing of results.

I kept observational notes throughout the interviews which were used for comparative analysis to participant responses. Taking notes increased the reliability of the data in the event that audio and video equipment failed (Creswell, 2014). I also maintained notes on thoughts and concerns related to the study to include reflections on the process, emerging themes, categories, theories and ideas. The process of

phenomenological theory is observing emerging information to reveal common themes about the constructs of the study (Creswell, 2014). I identified and recorded content and themes in words, descriptions, explanations that participants referred to throughout their interviews which explained sexual functioning, womanhood, and postsurgical decision attitude. Meaningful data was taken from similar shared experiences across participant's responses to the interview questions.

Data Analysis

Each interview was conducted in the same manner beginning with researcher's epoché, transcendental-phenomenological reduction, imaginative variation, and synthesized until saturation. Qualitative data analysis required me to perform consistent and immediate analysis of data throughout the data collection process in a fluid cyclical manner: a) identify, b) examine, c) interpret patterns and themes of the textual data, and 4) determine what themes and patterns emerged in the data that answered the research questions (Pell Institute for the Study of Opportunity in Higher Education, 2019). Each interview was recorded and transcribed. Transcripts were completed and reviewed after every interview was done to provide me with an opportunity to be objective, unbiased and begin performing reduction on the data. Data reduction is the process of identifying meaningful information within the qualitative data that is relevant to the research questions (Pell Institute for the Study of Opportunity in Higher Education, 2019). Interview questions were edited only if the participant demonstrated difficulty answering or understanding the question and if responses were not elaborate. Content and themes were created during the research process after each interview using deductive coding.

Coding allowed me to further understand and analyze participant experiences by forming manageable and meaningful content from the data (Pell Institute for the Study of Opportunity in Higher Education, 2019). Deductive coding provided me the opportunity to build the codes from common phrases, themes, and definitions of the research concepts of sexual functioning, womanhood, decision regret, and decision satisfaction from past research.

Research Credibility

The credibility of qualitative research is established through trustworthiness of what the researcher derives from the data. A qualitative study achieves trustworthiness when it can demonstrate that data analysis was conducted in a rigorous, exhaustive manner through concise, consistent, and systematic recording of data (Creswell, 2014).

Credibility

Member checking was conducted allowing participants to review their transcribed interviews for errors, intentions and descriptions of experiences to increase the credibility of the data collected in the interviews. Reviewing the content and themes derived from the interviews enabled participants to correct or confirm interpretations also increased credibility and internal validity of the interview questions (Korstjens & Moser, 2018). Allowing participants to share their lived experiences and review their interviews to correct misinterpretations or elaborate further towards deliverable meaningful data and accurate representation of the phenomena or research interest.

Transferability

Transferability is obtained through thick description which explains the context of participants and how the research was conducted: Purposive sampling was used to identify inclusion and exclusion criteria, sample size, age, interview procedure, interview topics, thematic coding, assumptions, and setting (Korstjens & Moser, 2018). Additional research can be conducted to increase understanding of participant experiences, other areas of health and functioning that were affected by a hysterectomy and explore ways to improve surgical outcomes and experiences. Data gathered in the interviews increased the understanding of participant experiences with presurgical consultations and healthcare professionals which may impact and improve physician and patient interactions. The wealth of information obtained through qualitative studies increased understanding of the phenomenon and revealed other areas of researchable interests.

Dependability and Confirmability

Dependability and confirmability of a qualitative study is transparency of the analysis process by maintaining inter-subjectivity and describing the research process from the start to the end and representation of the findings (Korstjens & Moser, 2018). This research includes a description of the research and analysis process to include the inclusion interview, participant demographics, data collection, interview process, interview notes, data analysis, exclusions, limitations, areas for further research, and contributions for social change. This research also includes researcher bias, preconceived assumptions and considerations for further research after final data analysis.

Ethical Concerns

Ethical practice and application remained a primary concern throughout the study. The Belmont Report (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979) is the universally accepted ethics practice ensuring the autonomy of participants (respect to persons), minimal risk (beneficence), fair distribution of risks and benefits (justice), and researcher obligation to the sharing of research findings (respect to community) is maintained. IRB approval was obtained #06-08-20-0083377 prior to building the online informed consent and inclusion questionnaire. I prioritized the full understanding and consent of all participants. Informed consent was obtained from every participant before they engaged in the inclusion questionnaire. This was necessary for any participant to initiate the study. The letter of Informed Consent adhered to all federal guidelines, including an explanation of procedures, risks, reasonable expectations, an offer of inquiry, and participant rights to withdraw (Frankfort-Nachmias & Nachmias, 2008). In the event of withdrawal or participant refusal to participate, the participant was dismissed, and I contacted another participant who met inclusion criteria. All participants in the study were over the age of 18 and consensual free of any mental impairment or capacity, which was part of the inclusion criteria. Any participants experiencing adverse effects or emotional reactivity to the interview that might prohibit their ability to continue were offered an opportunity to end the interview and continue at a later date, discontinue and seek medical or psychological support, or withdraw. Any adverse reactions are discussed in the findings and final analysis of this study.

All recorded materials in this study will be maintained for up to but not exceed 5 years, pending final approval by the research committee, minimizing any possible breaches in confidentiality. At that time all transcripts, recordings, notes, and related materials will be properly discarded and destroyed. There will be no participant identifiable data in the study. Each participant will be designated by participant number, such as P1, P2, and so forth. The informed consent provided participants with the understanding of how the results of the research would be shared for academic purposes. Full disclosure of my research intent and use of the findings were shared with the participants maintaining ethical transparency. The inclusion criteria for participants required that all participants were healthy physically and psychologically to share what might be considered a life altering experience.

Summary

The purpose of this chapter was intended to outline the research method used to answer the research questions of this study. The chapter was a discussion of the research procedure, participants, data collection, data analysis, interview questions and any other specifics of the how the study was conducted. This study was based on a phenomenological theory methodology and not intended to offer a direct explanation or solution to a given problem, but to explain a common phenomenon which existed across a particular population. All study participants willingly shared their experiences and perspectives on this common issue to increase awareness and understanding. The goal of this chapter was to explain the process and Chapter 4 provides the results of this study and demonstrates the methodology of this chapter and how it was followed.

Chapter 4: Results

Introduction

The purpose of this chapter is to present the results of this qualitative study. This chapter reviews the purpose of the research questions and how they were answered. This chapter will review the setting of the study to include the demographics of research participants the coding process of the data, and summation. This chapter interprets the study results by reviewing the data collection, analysis process and strategies used to confirm the credibility of the findings. Common themes among participants' responses are discussed and explained.

Setting

The purpose of this study was to identify a specific population of women between the ages of 19 – 36 who elected to have a hysterectomy, after physician recommendation, for a benign reproductive issue. A thorough review of previous research and statistics identified that over 600,000 women have a hysterectomy each year and up to 60% of the procedures performed were for benign health issues (Chou et al., 2006). It was later discovered through further research and participant pooling that the age demographic was more expansive between ages 18–40 with significant numbers of the women being between ages 25–38 most specifically. Many women reported benign issues occurring in late adolescence and physicians making a recommendation over alternative treatment options in their late 20s to late 30s. I requested a revision to the IRB to expand the age demographic as many women reported their family planning stages to be between ages 30 – 40. The study sought to recruit women of any age who had an elected hysterectomy

between the ages of 18 – 40 meaning a woman at age 40 or higher could participate if the surgery occurred during the specified age range. Some important considerations were given to the length of time from the surgery when recalling events and experiences. In most cases, participants reported that they still felt emotionally charged and still deeply effected in other areas of their life because of the surgery. This research will not provide an in-depth analysis of this aspect of experience although it proves to be a researchable topic because of the research conducted. Other recommendations will be discussed in Chapter 5.

Demographics

All women who participated in the study, N=15, were between the ages of 18–40 when they had a hysterectomy procedure, and between the ages of 32–62 at the time of the interview. All women in the study reported no history or diagnosis of malignancy or abnormal tests prior to electing a hysterectomy. All participants were from various areas across the United States, randomly selected after completing the inclusion questionnaire. Each participants' questionnaire was reviewed to meet two basic criteria for selection: First, was the hysterectomy performed between the ages 18–40, and second, no history or diagnosis of malignancy. Women were not invited to participate in the face-to-face interview if they did not meet these two criteria. Race, ethnicity, or age was not a deciding factor for invitation to participate in the final interview. Other questions asked in the inclusion questionnaire supported interview questions asked in the face-to-face interview. The interview questions were developed to answer the central research question and subquestions.

Data Collection

The approach for data collection was changed from the proposal, due to COVID-19. I had reached out to local Obstetric/Gynecologists, physicians and women's health centers, in the Austin, Texas area, regarding the study and identified providers who were willing to post recruitment flyers. Letters were sent to identified, local physicians in the Austin, Texas area, with flyers that outlined the study, purpose, and my contact information. Statewide shutdowns to minimize the spread of COVID-19 required physicians to move to online telemedicine and prevented the posting of flyers. A request to change approach was submitted to the IRB twice during a 2-month period towards the recruitment of participants. A request was submitted to change the participant age range from 19-36 years of age to 18-40 and to pool participants from Walden's participant pool. The other request was submitted to recruit through social media platforms. The latter proved to be an effective recruitment process and 14 of 15 participants were recruited through Researchandme.com with one participant recruited through Walden's participant pool. All participants completed an informed consent prior to participating in the study. The informed consent and participant inclusion questionnaire, Appendix A, were given via Google Docs and once this was completed, I was notified through Researchandme.com or Walden's participant pool to review the completed questionnaire and accept or reject participants based on criteria. Thirty-five women completed the informed consent and questionnaire. The first 15 women who completed both and met the criteria of being between 18 and 40 years of age with no history or diagnosis of cancer or malignancy were invited to the face-to-face interview. Five out of the 15 participants

invited to participate in the interview dropped from the research and the next five participants on the completed questionnaire were invited to an interview who accepted and then completed the interview.

The face-to-face interview was conducted on Zoom and recorded. This was disclosed to the participant via the informed consent. Each interview was completed in 30-60 minutes dependent upon the elaboration and expression of personal lived experience offered by the participant. All interviews were conducted as planned with the exception of two where the participant was unable to connect to video or had technical difficulty for lack of understanding how to use technology. In these two situations, I used Zoom and had clients call in rather than use video. The sessions were still recorded and used to transcribe the interviews.

I did not deviate from any of the interview questions with the exception of probing statements and questions such as, “tell me more about that”, “tell me what that was like” “what else can you tell me about that?” and “what do you mean by that?”. One additional question was asked to support the interview question, “what does motherhood mean to you?” Many participants responded to this question with “it is important to me”. This did not capture the perspective of defining what motherhood meant to the participant; therefore, a follow-up question was added to have participants elaborate with “what are your thoughts on the relationship with motherhood and being a woman”. This question was developed and added as a probing question to support the original interview question after two participants stated they perceived motherhood as a natural stage of

womanhood. Participants that perceived motherhood as not being related to womanhood were asked to elaborate.

Data Analysis

After each interview was completed, transcribed, sent to participant and received, I began analyzing the responses to the interview questions and looked for emerging themes. The first analysis was to separate all information in the participant inclusion questionnaire for each participant. This consisted of separating participants according to age they were when they had the procedure and what benign condition they were diagnosed with. Other items separated out of the questionnaire responses were number of children and whether they were biological, stepchildren or adopted. Other important information not gathered from the interview but captured in the inclusion questionnaire included participants' experiences with healthcare professionals, what type of professional they spoke to and how many visits they had prior to surgery. All this information was important in the demographics of participants and in the explanation of theoretical models used for this study.

I used the research questions to identify the central themes of participant responses and related themes or subthemes that aligned with the central themes. The central research question involved the perceived experiences of womanhood, sexual functioning and decision attitude of participants who elected a hysterectomy for a benign reproductive issue; therefore, the common central themes of the research were sexual functioning, womanhood, and decision attitude. How participants perceived the meaning of sexual functioning were the concepts typically identified in the normal human sexual

cycle: Desire, arousal, and climax. During the interview, most common responses to sexual functioning included participants' perceived desire or interest to have sex, arousal ability, and whether participants achieved an orgasm or climaxed during sexual intercourse which many participants associated with sexual satisfaction. Notably, women who reported they could easily progress to climax experienced sexual satisfaction. Participants responded to questions about womanhood which revolved around being a mother, sexuality related to intimacy and identifying as a woman in the female physiological state. The final theme was participants' attitude towards their decision and the responses were either positive, negative or ambivalent in nature.

Participants were asked to share their postsurgical experiences with sexual functioning. The interview question specifically asked about sexual desire, sexual arousal and sexual satisfaction. No other questions or information was given, and I used participants' responses to formulate emerging themes and common perceptions of those three stages. Some participant responses to desire were: "I no longer desired sex", "I just wasn't interested in sex anymore", "I had no libido", and "I didn't have much of a drive anymore" were all grouped into the subtheme of desire, under the overarching theme of sexual functioning. Statements on arousal and orgasm were more explicit.

The research question asked for women's perceptions of womanhood and how they identified with womanhood. The interview question asked women for their thoughts about motherhood and the relationship it has with being a woman. Participants mainly responded to this question with the level of priority it had in their life and several emphasized that the meaning of being a mother was: "The most important thing to me is

being a mother"; therefore, I had to provide a probing question which followed up the question with "what is the relationship between motherhood and being a woman?" Once this question was asked, many women better understood the purpose of the question and identified that the ability to conceive and fertility were a sign of femininity and sexuality (being a woman). Responses such as "a woman without breasts, in my opinion, is like a woman without ovaries. You're missing something that makes you a woman and attractive to men". Therefore, I grouped intimacy with sexuality as several participants reported that the inability to conceive or being infertile, caused significant disruptions in intimacy and attractiveness with their partners, "I do think that although not all men want kids, or hold that as highly important, I do think that they find it important and appealing for a woman to be fertile as they associate that with being normal". Other participants identified womanhood in the concepts of the basic anatomical model, gender role or social norm perspective "I don't think that all women have to be mothers; however, I think fertility and basically having the reproductive organs is what makes you a woman", and "from the time we are little girls, we are socialized to be little mother hens to our dolls, younger siblings, and pets. It's part of this whole gender role and socialization". I grouped all common responses to this as femininity.

The final portion of the research question referred to women's perceived disposition towards their decision to elect a hysterectomy and whether or not it was the best choice for them after taking into account their experiences with sexual functioning and womanhood. The interview question asked whether women would change anything about their experience or have done anything differently. Participants responded to this

question in one of three ways: Positive, negative, or ambivalent. Women who reported that they would not change anything at all and reported less recurrent negative physical symptoms were positive about their decision. Such responses included a direct “no”, “I wouldn’t change anything”, and “I did the best with what I knew at the time and at least I don’t have those problems anymore”. Women who reported a negative experience made statements of regret such as “I wish I would have gotten a second opinion”, and “If I knew then what I knew now, I wouldn’t have done it”. Participants who shared an ambivalent attitude reported “no-win situation”, and “I can’t change it now, so I just try to help other women”. The themes, sub-themes and common descriptions can be found in Table 7.

Evidence of Trustworthiness

According to Creswell (2014), qualitative studies require a rigorous, exhaustive process of data analysis to achieve trustworthiness. The data collection process was carried out concisely and consistently from the beginning to the end of the study.

Credibility

Participants were chosen through purposive snowball sampling. The initial proposal of the study was based on snowball sampling; however, due to COVID-19 and the need to change the approach, purposive sampling was incorporated through the recruitment of participants via a social media platform. Some women who chose to participate in the study referred other participants. All participants followed the same process by engaging in the online informed consent form and inclusion questionnaire. Through the use of data triangulation, participants were interviewed at a later date from

the original information provided in the online inclusion questionnaire. If their responses differed from originally shared information, I asked for clarification of responses. I invited the first 15 women who completed both preliminary steps and invited them to the face-to-face interview. If a participant did not respond within 72 hours of the invitation and 2 reminders, I chose the next participant from the list of completed consent and questionnaire. This continued until all 15 participants had scheduled and been interviewed. Completed interviews were reinterpreted through the use of member checking as I transcribed each recorded interview within 24 hours and sent to the participant to review. Each participant was given 72 hours to review the transcription and add or retract any information they chose to. Each transcript was returned within the 72 hours and the coding process began. Persistent observation was used to ensure that the main or central themes of data answered the research questions and were clearly representative of what the question asked. Sub-themes were revised after reading and separating each response and reassessing its content and relativity to each question. Emerging themes that were unrelated to the study but suggested a viable interest for further research were noted to be discussed in Chapter 5 recommendations.

Transferability

All participants were recruited via social media platforms to include Researchandme.com, and the Walden Participant Pool. A link to the online informed consent, created in Google Docs was provided on the Researchandme.com website, permitting all participants to click on the direct link to the consent form and inclusion questionnaire. The Walden Participant Pool link did not permit external links; therefore,

the consent form and questionnaire were recreated directly into the provided space on the taken during the interview were cross referenced during the transcription. Transcribing the interviews allowed me to review the interview again, compare against notes taken and ensure that participants' responses were recorded accurately. All nuances and idiosyncrasies were captured and transcribed. Even if the participant stated "like", "um" or cursed during the interview, it was transcribed for the participant to review. Only the participant had the ability to add or retract statements.

Dependability and confirmability

Dependability is the ability for the study to be repeated by other researchers and yield consistent findings. The process of participant recruitment and questions asked are explained throughout the study and reviewed by the Dissertation Chair, Committee Member, and Research Reviewer. The participant recruitment process and interview questions were used consistently throughout the study. Using open ended questions allowed participants the opportunity to share their experience without leading and researcher bias. I adhered to only the interview questions and did not engage the participants in any other discussions or side talk. Interview questions were reviewed by the Dissertation Committee to ensure they aligned with the research questions presented. Confirmability was established through member checking of transcribed interviews and having participants confirm their responses to each of the interview questions. Using this process enabled me to capture the true essence of the participants' experiences without bias. Emerging themes were developed based on the research questions and after each interview was transcribed. Responses to each question was reviewed and matched with

themes that best captured each participants' experience. By coding after each completed interview, I was able to reach saturation.

Reflexivity

The researcher-maintained awareness of potential personal biases and experiences with the topic of the study. Although these perceptions existed, previous research explorations suggested a phenomenon. Using a social media platform for recruitment provided an opportunity to recruit participants across the country without any connection. Participants varied in location, age, race, ethnicity, and sexual orientation. I had no prior knowledge or encounters with any of the participants. Participants' responses and experiences were authentically shared without influence or leading questions. The findings demonstrated that there may be a phenomenon behind the topic of study and presented several recommendations worthy of future research.

Results

Participants' ages ranged from 25 – 39 with the youngest participant being 25, and two participants being 39 years of age. Three participants were 38 years old at the time of their hysterectomy and two were 28. The rest of the participants were various ages within that range. There were no common relationships found among the age ranges; however, a common theme was found in the diagnoses.

Participants were asked to share, in the participant inclusion questionnaire, what benign condition they were experiencing at the time a hysterectomy was recommended (Table 1.): Polycystic ovarian syndrome (PCOS), endometriosis, dysmenorrhea, abnormal uterine bleeding, (UAB), menorrhagia, premenstrual syndrome (PMS),

premenstrual dysphoric disorder (PMDD), adenomyosis, or uterine fibrocystic fibrosis. Some participants reported one or more diagnoses which complicated symptoms and treatment options. Participants with multiple diagnoses reported that compounding and recurrent symptoms influenced their decision which is discussed further in the theoretical framework used for this study. Participants with compounding diagnoses of one or benign conditions influenced the type of procedure and in many cases received recommendations to have a more evasive procedure. This is later analyzed in the theoretical model used for this study and how it relates to health decisions.

Table 1

Participant Benign Conditions

Benign condition	*n*	%
PCOS	10	67
Dysmenorrhea	4	27
Endometriosis	7	47
Pain	5	33
Uterine fibroids	1	6
AUB	7	47

Table 2 demonstrates participants identified by which hysterectomy procedure they had in the participant inclusion questionnaire. Table 3 demonstrates the number of women $n = 10$ who were diagnosed with PCOS had either a total hysterectomy $n = 4$, or a total hysterectomy with bilateral oophorectomy and salpingectomy $n = 6$. This included all women who also had a diagnosis of endometriosis $n = 7$. Each procedure according to diagnosis is demonstrated in table 2.

Table 2

Procedure Type Results

Type of Hysterectomy	*n*	%
Subtotal (no uterus with cervix and ovaries intact)	5	33
Total (removal of uterus, cervix and one ovary)	4	27
Total with bilateral oophorectomy and salpingectomy	6	40

The type of procedure was then compared to women who reported an increase in sexual functioning, decrease or no change with respect to the cycle of sexual functioning: Desire, arousal, and orgasm. Women who experienced significant pain, prior to a hysterectomy $n = 5$, only 60% reported improved sexual functioning $n = 3$ after a total bilateral procedure. The other 40% had a total procedure with one ovary intact $n = 2$. Only 60% of women who had a subtotal hysterectomy $n = 3$ reported no change in sexual functioning. This indicated no improvement, no decrease which implied women perceived their sexual functioning to remain the same as it was prior to surgery.

Table 3

Recommended Procedure to Benign Condition

Procedure type	PCOS	Dysmenorrhea	Endometriosis	Pain	Uterine fibroids	AUB
Subtotal	0	3	0	0	1	3
Total	4	1	1	2	0	0
Total bilateral	6	0	6	3	0	4

All women who had a total hysterectomy with bilateral oophorectomy and salpingectomy $n = 6$ and 75% of women who had a total hysterectomy with one ovary intact $n = 3$ reported no desire for sex $n = 9$. Only 70% of those women, n = 7 reported

difficulty with arousal and 40% reported inability to reach climax *n*= 4. Only 50% of women who underwent a total hysterectomy with bilateral oophorectomy and salpingectomy reported having difficulty with all 3 areas of sexual functioning. Consistently, participants' who stated their sexual functioning was normal or increased prior to having a hysterectomy, reported that it either didn't change or had increased. Sexual functioning was not quantitatively measured in this study and all accounts were from a subjective perspective and self-reported. What was significant were women's perceived experiences about sexual functioning and how it impacted them. Notably, most women experienced changes 1-2 years postsurgery.

Table 2

Sexual Functioning According to Procedure Type

Procedure type	Improved	No Change	Desire	Arousal	Orgasm	Pain
Subtotal	0	3	0	0	0	0
Total	0	0	3	4	1	2
Total bilateral	3	0	6	3	3	3

Thematic coding

Each interview was transcribed and separated by question and response. Each interview question aligned with a research question and responses were grouped together and reviewed for common themes that emerged from each response. A final deduction of responses to three of the four sub questions was used to answer the central research question of the study. The fourth sub question is explained in the theoretical model used for this study.

Sexual functioning

What changes in sexual functioning do young women, ages 18 to 40, experience after a hysterectomy? There were 12 common themes found supporting this research question with the interview question, “after your hysterectomy, what were your experiences with sexual desire, sexual arousal, and sexual satisfaction?” The themes were, in order of most common to least common experience: No change from 1 to 5 years postsurgical; no desire; no interest; no arousal; pain; inability to achieve orgasm, and sex felt different. Participants who reported they did not experience or notice a change in sexual functioning, $n = 11$, reported that they didn’t begin to notice a change in sexual functioning until one year post surgery, $n = 3$; two to four years, $n = 4$; or, five or more years, $n = 4$. Of these participants, who experienced no changes until years after the surgery, $n = 9$ experienced no desire. Additionally, $n = 7$ reported not being interested in sex; however, could not attribute that completely to having had a hysterectomy. Desire and interest in sex was combined into one sub-theme of sexual functioning, including positive, negative, and ambivalent experiences. Additional sub-themes under the overarching theme of sexual functioning which emerged from participant responses were sexual arousal, sexual satisfaction, orgasm and climax.

Perceptions of motherhood. How do young women, who elected a hysterectomy, describe their perception of motherhood? There were twelve common themes supporting this research question with the interview questions, “what does motherhood mean to you? What are your thoughts on the relationship between motherhood and being a woman?” and “how has a hysterectomy affected your views on motherhood knowing you cannot naturally conceive, carry or bear a child?” Common themes were separated into sub-

themes which participants all believed encompassed womanhood and the prospect of motherhood. Sub-themes under womanhood were: Motherhood, intimacy and sexuality, and femininity. The themes were, in order of the most common to least common experience: Motherhood is a natural stage of a woman's life; social/gender expectation; fertility is an indicator of femininity and sexuality, and loss of ability to conceive caused intimacy and closeness issues in a relationship. Participants who perceived that motherhood is a natural stage of a woman's life, $n = 8$ also indicated that being a mother was very important to them. Participants who attributed motherhood as a social/gender expectation, $n = 6$, also indicated that society and social constructs dictate there is an expected course to a woman's life which includes graduating from high school, going to college, meeting a partner, marrying and having children. Participants also perceived fertility as an indicator of femininity and attractiveness, $n = 5$, suggesting men find fertile women to be "normal", sexual beings and good prospects for a relationship and marriage. Participants who were married or in a committed relationship with a partner, $n = 4$, indicated that their inability to have children contributed to marital or relationship discord resulting in separation or divorce and negative outlook on future partnerships. Women who had a hysterectomy between the ages 25 – 35 reported that low sex drive and inability to conceive and bear children affected any possibility of future relationships stating, "I have nothing to offer a man". Participants who had one or more biological children already, $n = 11$, reported less effected self-perceptions of womanhood. Participants who had at least one biological child and had no plans to have more children reported a less negative attitude towards electing a hysterectomy. Women who had not

had any children, biological or adopted reported a more negative attitude towards their decision to elect a surgery and a more negative self-perspective.

Table 3

Participants and Children

No children	1–2 children	3–4 children	Wanted Children	Didn't want children
4	8	3	10	5

D*ecision Attitude*

Among young women who have had a hysterectomy, what is their postsurgical experience regarding their decision? There were eight common themes found supporting this research question using the interview question, "given your experience up to this point, would you have done anything differently?" The overarching theme was decision attitude separated into three subthemes: Positive, negative and ambivalent. Positive outlook encompassed three common themes: Wouldn't change anything, living symptom free and perceived their decision as a prevention to possible future health issues. Participants who reported a negative perception towards their decision to elect a hysterectomy shared three common themes: Regret with not seeking a second opinion, decision regret, and not having enough information regarding postsurgical outcomes. Participants who perceived their experience and decision was neither positive nor negative reported an ambivalent perspective in two common themes: Perceived no-win situation and complete trust and confidence in their healthcare provider's recommendation. Overall, majority of participants, 47%, reported a positive attitude towards their decision to elect a hysterectomy.

Table 4

Participant Decision Attitude

Positive	Negative	Ambivalent
7	4	4

It was discovered that most participants shared a common perspective of the themes captured in the data. Among the responses to the interview questions, most women shared a similar perspective of sexual functioning and womanhood. Postsurgical attitudes involved a more overall collective experience between the two and I had to deduce the perceived evaluation of each participants' experience, if it was not stated explicitly. Table 7 demonstrates the overarching themes and sub-themes found in the data collected between the participant inclusion questionnaire and the interview.

Table 5

Common Themes and Subthemes of Participant Lived Experiences

Theme: Sexual Functioning	Theme: Perceptions of Womanhood	Theme: Decision Attitude
Subtheme: Desire, interest Libido, and drive	Subtheme: Motherhood	Subtheme: Positive
• Sex was the furthest thought from my mind. • Sex isn't a priority. • Lack of symptoms improved sex. • There was no change.	• Being a mother is part of being a woman such as next step. • Means ability to have child. • A natural stage of a woman's life. • Is a social/gender expectation.	• Wouldn't change anything. • Living symptom free. • Prevention solution.
Subtheme: Sexual arousal	Subtheme: Intimacy, sexuality	Subtheme: Negative
• My drive/libido wasn't the same. • Took a lot to get in the mood. • There was dryness and pain. • Feelings of inadequacy and defectiveness.	• Men find fertile women "normal" and sexually appealing. • Expectation to be a sexual being, fertile and homemakers. • Lack of interest in sex created lack of intimacy and closeness. • Feelings of failure and insecurity.	• Would have sought a second opinion • Decision regret • Not well informed of outcomes.
Subtheme: Sexual satisfaction, orgasm, climax	Subtheme: Femininity	Subtheme: Ambivalent
• Sex felt different. • I didn't want to be touched. • Couldn't have an orgasm. • Nothing to offer partner.	• Fertility is attractive and appealing. • Reproduction sets women apart from men. • Loss of female ability. • Loss of sexuality.	• Perceived no-win situation. • Trusted provider recommendation.

Summary

The process of identifying emerging themes within the data collected from participants' interviews was a rigorous and lengthy process. It required adhering to the purpose of the study and focusing on responses which directly or indirectly answered the research questions. Some participants directly answered questions with a synopsis of their

lived experience and those who responded indirectly with elaborate and detailed recollections, clarified their responses through member checking and reviewing their interviews. Ultimately, young women who elected a hysterectomy had a positive lived experience with sexual functioning and perceptions of womanhood, if the surgery eliminated all physical recurrent symptomology of their reproductive condition and they were able to conceive and bear children prior to the surgery. Women who experienced a total hysterectomy with bilateral oophorectomy and salpingectomy were most affected one to two years postsurgery in areas of sexual functioning which included reduced desire, difficulty with arousal and achieving orgasm. In most cases, these women reported having low libido and minimal sexual satisfaction. More than 50% of women associated motherhood as a woman's natural endowed ability and a social expectation after marriage and 67% of women expressed disappointment because they wanted to conceive more children. Most women received presurgical information regarding a hysterectomy from family and friends who had undergone the procedure and researched the internet rather than speaking to a healthcare professional. In conclusion, more than a third of the participants held a positive attitude regarding their decision to elect a hysterectomy reporting that living symptom free was more ideal than managing their recurrent reproductive issue.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to understand the lived experiences of young women, ages 18-40, who elected to have a hysterectomy for a benign reproductive issue and how it affected them in areas of sexual functioning and self-perceptions of womanhood. In understanding their experience, women were asked to share how those experiences affected their attitude towards their decision to elect the surgery. Areas of sexual functioning included sexual desire, arousal, and climax. Face-to-face interviews with participants, via social media platform, revealed common themes in their experiences that was dependent upon which type of hysterectomy procedure they had. The findings also revealed common themes in what women perceive to be important aspects of womanhood, which included motherhood, femininity, and sexuality. Women who held unaffected, improved, or unchanged sexual functioning and self-perceptions reported a positive experience. In addition, what could be attributed to a positive experience included presurgical information women received regarding postsurgical expectations and how women perceived associated health risks and long-term implications. An in-depth interpretation of these findings will be discussed in this chapter.

Interpretation of the Findings

Previous studies conducted on postsurgical implications of a hysterectomy on women was explored for gaps in the research and discussed throughout Chapters 1 and 2. Upon completion of the study, there were a number of insights gained that aligned with

previous research and confirmed findings. The primary finding was not all women in the study experienced changes in sexual functioning with the exception of women with a supracervical (partial) hysterectomy and removal of one or both ovaries, and women who had a total hysterectomy with bilateral oophorectomy and salpingectomy. Changes in sexual functioning may have directly impacted women's self-perceptions of womanhood. How these two areas of social functioning were affected, directly or indirectly, affected women's postsurgical attitudes toward their decision to elect a hysterectomy. Surgical menopause attributed to the hormonal, physiological, and psychological changes. Ussher et al. (2015) asserted that women who positively negotiated the effects of menopause based their perceptions on already held appraisal of cultural and social constructs of womanhood (motherhood, femininity, and sexuality). In this study, it was identified that all women who had a hysterectomy, received it for the same benign reproductive issues and diagnoses. Several of the women held negative attitudes toward their decision with the exception of those who had the opportunity to have biological children and had accepted minimal sexual drive and satisfaction. I evaluated previous studies used in the literature review to confirm or disconfirm how a hysterectomy affected women's sexual functioning, perceptions of womanhood, and decision attitudes.

Previous research on sexual functioning revealed that 83% of women, in a population of $n = 115$, reported they did not experience a decrease in sexual desire, arousal, or ability to achieve orgasm after a laparoscopic supracervical or total hysterectomy which included the removal of the uterus and cervix (Pouwels et al., 2015). This varied from the findings of 75% of women, in this study, reporting a decrease in

desire and arousal; however, Saini et al. (2002) confirmed over 35% of 27 women who underwent an abdominal supracervical and total with bilateral oophorectomy and salpingectomy reported reduced sexual functioning. Meston (2004) revealed that women who underwent a hysterectomy for benign uterine fibroids experienced adverse pelvic autonomic nerve responses reducing erotic stimulation and arousal. Considerable amount of research revealed a high number of women who experienced negative changes in sexual functioning after having a hysterectomy, whether laparoscopically, abdominally or vaginally due to damage in the anatomical structures of the pelvis, shortening of the vagina after removal of the uterus and cervix leading to loss of vaginal lubrication and sensations (Lermann et al., 2013; Levin, 2005; Rannestad et al., 2001; Topatan & Yildiz, 2012; and Wong & Arumugam, 2012.) The difference was in the physical structures affected which could be attributed to surgical trauma, injury, neurological damage, or endocrinologic changes.

Womanhood is a construct which has been defined and researched in many ways. Naidoo (2010) defined womanhood as the passing of menarche and a woman's social gender role which is often associated with femininity and used collectively to describe women as the foundation of domesticity. The concept of womanhood is often associated with sexuality in terms of sexual status, capacity, and potentialities in both biological and social dimensions (Uko, 2014). Other research suggests sexuality is a psychological or cognitive state not solely physical (Chivers & Brotto, 2017). For this study, I encapsulated existing constructs held in previous research to define womanhood. This study explored how this perception was affected when physiological changes, such as

reproductive surgery removed the biological capabilities of a woman's sexual functioning and conception. Social constructs to this concept would be femininity and how women viewed themselves as a sexual being. In this study, the findings confirmed that women do associate biological and social constructs with their reproductive organs and their ability to procreate, sexually function and be perceived in the social expectation of the female gender role. Several participants believed in the social expectations that women are meant to be sexual and eventually be homemakers, wives, and mothers.

Minimal research has been done to explore postsurgical attitudes of women who elected a hysterectomy; however, research presented and analyzed in Chapters 1 and 2 of this study explored pre- and postsurgical education women received for a hysterectomy. This study explored women's lived experiences with education and information received from healthcare professionals and how that impacted their postsurgical attitude. Hughes and Lewinson (2015) explored barriers to communication between aging women and healthcare providers on sexual health and founded that the main challenge was the facilitation of communication and the lack of women or providers to initiate the discussion. Although the study was not particularly directed towards women and a hysterectomy, it did confirm a common theme among participants that they did not discuss the topic of sexual health or functioning with their healthcare professional, and it was also not addressed. Karp et al. (2015) discovered in their research that the majority of women who underwent a partial or bilateral oophorectomy for benign issues never received any information from their healthcare professional on the post implications of how it may or may not affect sexual functioning. This was also confirmed in the study

that women were unaware or not informed of the correlation or direct impact of the removal of their ovaries. How women reconciled the decision to have a hysterectomy and the impact it had on their lives, particularly sexual functioning and perceptions of womanhood can be explained in the two theoretical perspectives: Robinson's Sexual Health Model (Fig. 1) and Roger's Protection and Motivation Theory (Fig. 2).

Each participant's interview was reviewed and analyzed using Robinson's Sexual Health Model to explain their responses. Robinson's model encompasses 10 key aspects of individual approach to sexual behavior:

- Talking about sex. I discovered a common theme among all participants in talking about sex with family, friends, and healthcare professionals. Most participants, 70% sought advice regarding having a hysterectomy from friends and family; however, none discussed sexual health to include discussions with healthcare professionals.
- Sexual health and safe sex. Almost all participants did not associate sexual health with well-being; therefore, they did not consider that to be a priority in their presurgical discussions about postoperative implications.
- Masturbation and fantasy. More than 63% of participants stated they were satisfied with no longer experiencing many of the negative symptoms they had prior to the surgery and accepted whatever consequences on their sexual functioning. In addition, they also accepted the taboos associated with sexual exploration and succumbed to whatever the outcome of the surgery was without question or pursuance of support.

- Spirituality. All participants perceived conception as a natural endowed gift. The percentage of participants, 73%, perceived motherhood as a special privilege, whereas the other 27% reported feeling inadequate. All fifteen participants perceived the female reproductive system as a woman's unique ability.
- Culture and sexual identity. All participants perceived motherhood as a natural stage of womanhood. There was a common perception that motherhood was the next stage after marriage and 60% experienced continuous stress and expectation from family and friends to have children. Of participants, 40% perceived they had nothing to offer a partner due to lack of sexual desire and ability to have children. Reduced libido and loss fertility was perceived as being "less of a woman".
- Challenges. Participants, 80%, experienced difficulty and reluctance to discuss sexual health with professionals and to ask the necessary questions. Most women reported they had a male physician that performed their surgery, and they were embarrassed to discuss how a hysterectomy might impact their sexual ability. Over 50% reported not knowing or realizing sexual health and hysterectomy were connected.
- Positive sexuality. Participant responses to how a hysterectomy affected their sexual functioning was analyzed with two commonly held views. More than half of participants accepted the consequences of the surgery on their sexual functioning and did not perceive themselves any less of a woman, whereas a third of women accepted the outcomes of their surgery but also wanted to learn how to improve sexual functioning and well-being.

- Sexual anatomy functioning. All participants who experienced a total hysterectomy with bilateral oophorectomy and salpingectomy reported a decrease in sexual desire, arousal and orgasm. This could be attributed to the physiological changes and how women reconciled and internalized these changes. All participants who experienced this type of procedure expressed decision regret and reported negative perceptions of sexuality.
- Body image. All participants reported their own challenges and subjective experiences with reconciling how a hysterectomy affected them and impacted their physiological and psychological health. Each woman expressed they felt differently about their bodies; however, only four expressed feelings of inadequacy.
- Intimacy and relationships. Women who reported a decrease in sexual functioning also reported a negative impact it had on intimacy with partners. Women who did not have children reported divorce shortly after having a hysterectomy. Women who reported failed relationships expressed decision regret for having the surgery and not trying alternative treatments or seeking a second opinion.

In understanding the behaviors of participants in relation to sexual health and their postsurgical attitude towards their decision, it became apparent to understand what caused them to choose to have the surgery. I used responses to the inclusion questionnaire and interview to understand the motivation behind women electing a hysterectomy for a benign condition above alternative methods of treatment. Participants were asked regarding the information they received from physicians and whether or not

they perceived they received adequate information towards making an informed decision. Women were also asked if any information was missing and why they chose to have a hysterectomy rather than alternative treatments. Using Roger's Protection and Motivation Theory, it became apparent that more than half of the participants perceived a risk of cancer and possibility of a malignant issues. Previous research on threat appraisal suggests the more threatening the information, the higher the motivation is to avoid the health risk (Ruiter et al., 2014). Mostly, women who experienced high fears and severity of possible cancer perceived the highest threat appraisal and appealed to intrinsic rewards such as peace of mind from recurrent symptoms. They turned to environmental and intrapersonal sources of information to validate that fear and their decision such as the internet, trust in healthcare professional's recommendations, and family or friends who had a prior experience. Women perceived their self-efficacy and response efficacy as a responsible health decision to choose a hysterectomy over alternative treatments because it minimized future possibilities of malignancy although there was no evidence of malignancy in the present or future. Contemplating the consequences between malignancy or reduced sexual functioning, more than 60% of participants claimed that the response cost (accepting physical and psychological changes) and changes in self-perceptions of womanhood clearly outweighed the decision to not elect a hysterectomy.

Limitations of the Study

There were a number of methodological limitations to consider within this study. The sample size and demographics of participants were within a wide range of ages, diagnosis type and procedure type. It was not narrowed to a particular demographic, age,

race, sexual orientation, benign reproductive diagnosis or type of hysterectomy which may or may not differentiate the number of external or internal influences that might have affected the outcomes. Limited prior research on the study topic has been conducted to provide an in-depth comparison of possible similarities and differences in the data gathered. The interview questions were derived from concepts within an already existing quantitative tool, the Female Sexual Function Index (FSFI) (Rosen et al., 2000); however, the questions do not capture a numerical representation of the impact subjective experiences had on each participant. Other limitations include participant self-reports. Several influences affect the validity and reliability of such data due to selective memory, attribution, and exaggeration. Researcher-level limitations were also recognized in the analysis of the data by ensuring that all possibilities of bias were perpetuated. After each interview, I reviewed quality of responses and if they answered the interview and research questions. I avoided influencing participant responses by not changing any of the questions and only utilizing four different probing questions and one follow-up question for clarification: “Tell me more about that”, “tell me what that was like” “what else can you tell me about that?” and “what do you mean by that?”, and “what are your thoughts on the relationship with motherhood and being a woman”. By adhering to the original questions, I was better able to use any other volunteered information which did not pertain to this study as recommendations for further investigation.

Recommendations

This study presented many opportunities for future research found in the responses given by participants. The current and previous studies conducted explored the

implications of a hysterectomy on sexual functioning, intimacy with partners, perceptions of womanhood and women's appraisal of health risks. All research explored the experiences of both women with benign and malignant health issues. Further research on the role of healthcare professionals in the decision-making process would be beneficial as much of the data presented in studies excludes this perspective. Further research on informed decision-making including the impact of cultural, social and religious influences, couples, physician recommendations and sexual orientation would also be a great contribution to the field. Longitudinal studies of postoperative experiences could be very informative on the progression of health-related problems or how long posthysterectomy do women begin to experience changes in functioning. This study revealed many women began to experience problems 1 to 2 years postoperative. Longitudinal studies on comparisons between alternative therapies and a hysterectomy could also provide further insights to whether a hysterectomy is the best course of action for benign reproductive issues and if less implications on sexual functioning are experienced.

Implications

The findings of this study have the potential to contribute to social change for women's healthcare, the reduction of healthcare costs, medical practice, and physician and patient communication. Based on participant responses to sexual functioning and the number of benign conditions women were diagnosed with preceding a hysterectomy indicates women are not fully aware of alternative treatments and prevention for reproductive issues. Given the number of studies on hysterectomies and how previous

findings were confirmed with this research, it is necessary for healthcare professionals to reconsider medical practice of recommending a hysterectomy for benign conditions. Consideration needs to be given to exhausting alternative options and treatments and a hysterectomy as a last resort. In discussing pre- and postsurgical visits and communication with healthcare professionals, participants reported a minimal number of appointments before making a decision to elect a hysterectomy. In their communications with providers, prior to surgery, many participants stated they did not discuss many of the options or post implications of the surgery. Although many participants stated their questions were answered, many admitted to not knowing what to ask. These findings suggest that presurgical information in physician consultations need to be improved and perhaps increasing the number of appointments and type of information shared before decisions are made and surgery is confirmed.

Knowing that there are several influences on women, as depicted in the use of Roger's Protection and Motivation Theory and Robinson's Sexual Health Model, suggests that presurgical consultations need to be focused on women's fear appraisals and validated. If there is no indication of cancer or possibility of malignancy, this is important to discuss towards helping women make an informed decision towards their own healthcare choices. In addition, women expressed the cultural and societal influences which affected them posthysterectomy in regard to childbearing, sexuality, femininity and intimacy with partners. These concerns need to be addressed in the pre- and post-consultations and drive postsurgical recommendations for support services if it continues to deeply affect women's overall well-being. One participant reported that continuing to

see an OB/GYN for any female issues, posthysterectomy, continued to trigger negative emotions, grief and regret especially when so many patients in the waiting area were pregnant.

Conclusion

A hysterectomy procedure is one of the most common surgical procedures performed. Extensive research and statistical data gathered by the World Health Organization (2009) suggests it will continue to be a common surgery used in the treatment and removal of benign reproductive issues. Given the amount of research conducted on the implications of such a procedure, it is evident that the long-term postsurgical symptoms pose a higher threat to overall well-being and quality of life for young women of childbearing years. Although a hysterectomy procedure may offer permanent relief to some reproductive conditions, the long-term implications are far more impactful on women's sexual functioning and self-perceptions of womanhood. Improving communication between healthcare professionals and women prior to recommending a hysterectomy should involve alternative treatments and expectations, family planning, sexual health, postsurgical well-being and future implications towards helping women to make an informed decision.

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Postsurgical

Appendix A: Participant inclusion questionnaire

1. How old are you?
2. What type of hysterectomy procedure did you have?
   - Subtotal (supracervical, partial) removal of uterus only with cervix and ovaries intact
   - Partial – removal of one or more ovaries with uterus and cervix intact
   - Total – removal of uterus and cervix only
   - Total hysterectomy with bilateral salpingectomy and oophorectomy
   - I don't know
3. How old were you when you had a hysterectomy?
4. Have you ever had a history of cancer or any other malignant reproductive issue? Malignancy refers to cancerous, possibility of cancer, or condition which leads to cancer)
   - Yes
   - No

   If so, please explain
5. What was your diagnosis? Check one or all diagnosed conditions that apply:
   - polycystic ovarian syndrome (PCOS)
   - endometriosis
   - dysmenorrhea
   - abnormal uterine bleeding (AUB)
   - menorrhagia
   - premenstrual syndrome (PMS)
   - premenstrual dysphoric disorder (PMDD)
   - adenomyosis
   - uterine fibrocystic tumors
6. What professional did you consult with?
7. How many appointments did you have prior to surgery?
   - 1-2
   - 3-4
   - 5 or more
8. What were your concerns regarding a hysterectomy?
9. What professional addressed your concerns?
10. Do you think this professional answered all your questions to your satisfaction?
    - Yes
    - No

If no, please explain:

11. What physical changes have you experienced since your hysterectomy that you did not anticipate?
12. How many pregnancies have you had?
    - None

- 1
- 2
- 3
- 4
- 5 or more

13. How many children do you have?
    - None
    - 1
    - 2
    - 3
    - 4
    - 5 or more
14. Please indicate if your children are biological, adopted or stepchildren.
15. What were your concerns about childbearing and having a hysterectomy?
16. Is it important to you to be a mother?
    - yes
    - no

Appendix B: Semistructured interview

1. What was your experience in discussing your sexual health with a healthcare professional prior and post hysterectomy?
2. Has a hysterectomy changed your sexual desire, ability to become sexual aroused, or experience sexual satisfaction?
3. What does motherhood mean to you? What are your thoughts on the relationship between motherhood and being a woman?
4. How has a hysterectomy affected your views on motherhood knowing you cannot naturally conceive, carry or bear a child?
5. What other options were discussed with you other than hysterectomy to treat your benign reproductive issue?
6. What influenced your decision to have a hysterectomy rather than the other options?
7. What was your experience with presurgical information on sexual functioning, family planning and postsurgical implications?
8. How did that information influence your decision?
9. What information was missing, if any?
10. Given your experience up to this point, would you have done anything differently?

Figure 1.

Sexual Behavioral Health Model

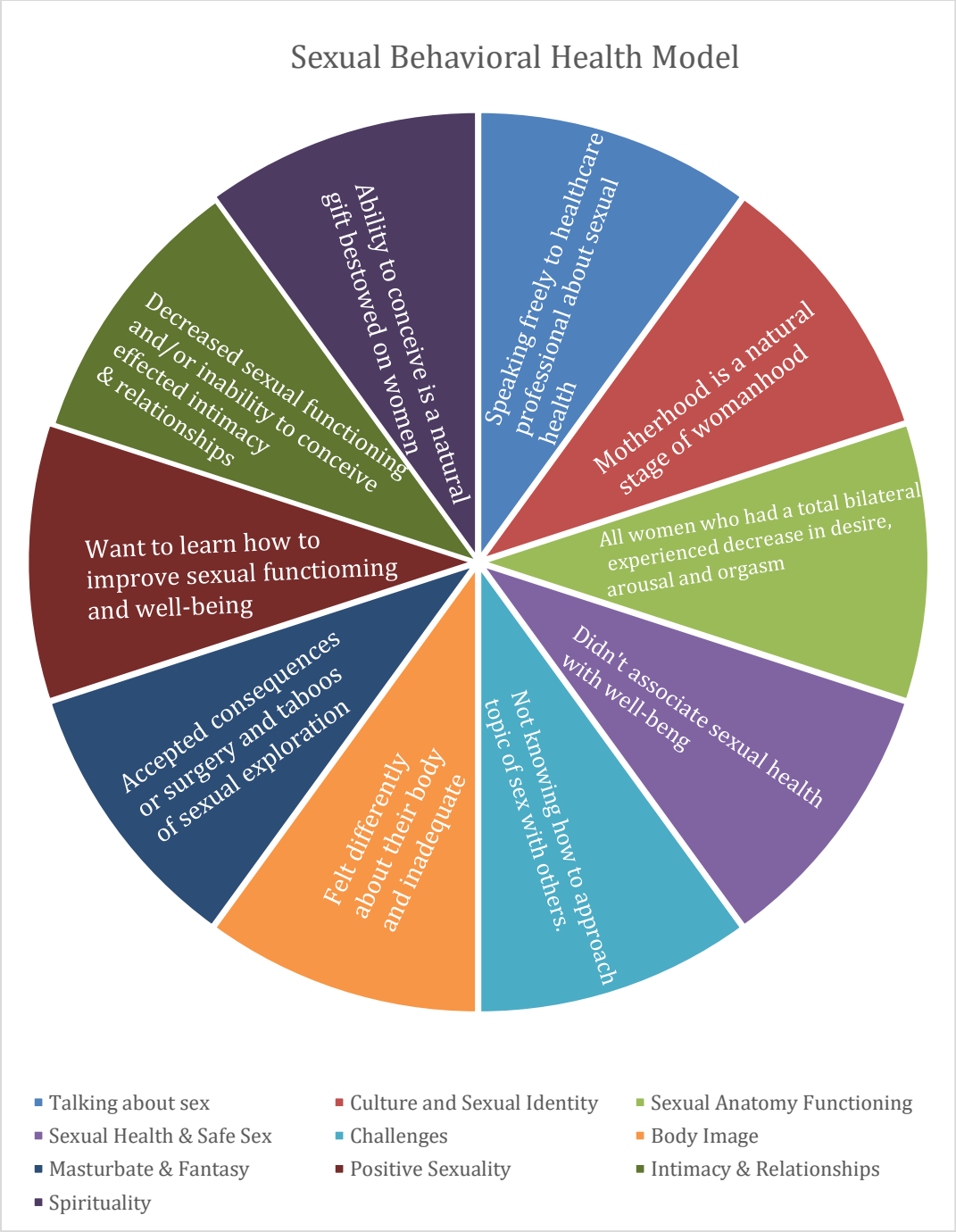

Figure 2.

Roger's Protection and Motivation Theory

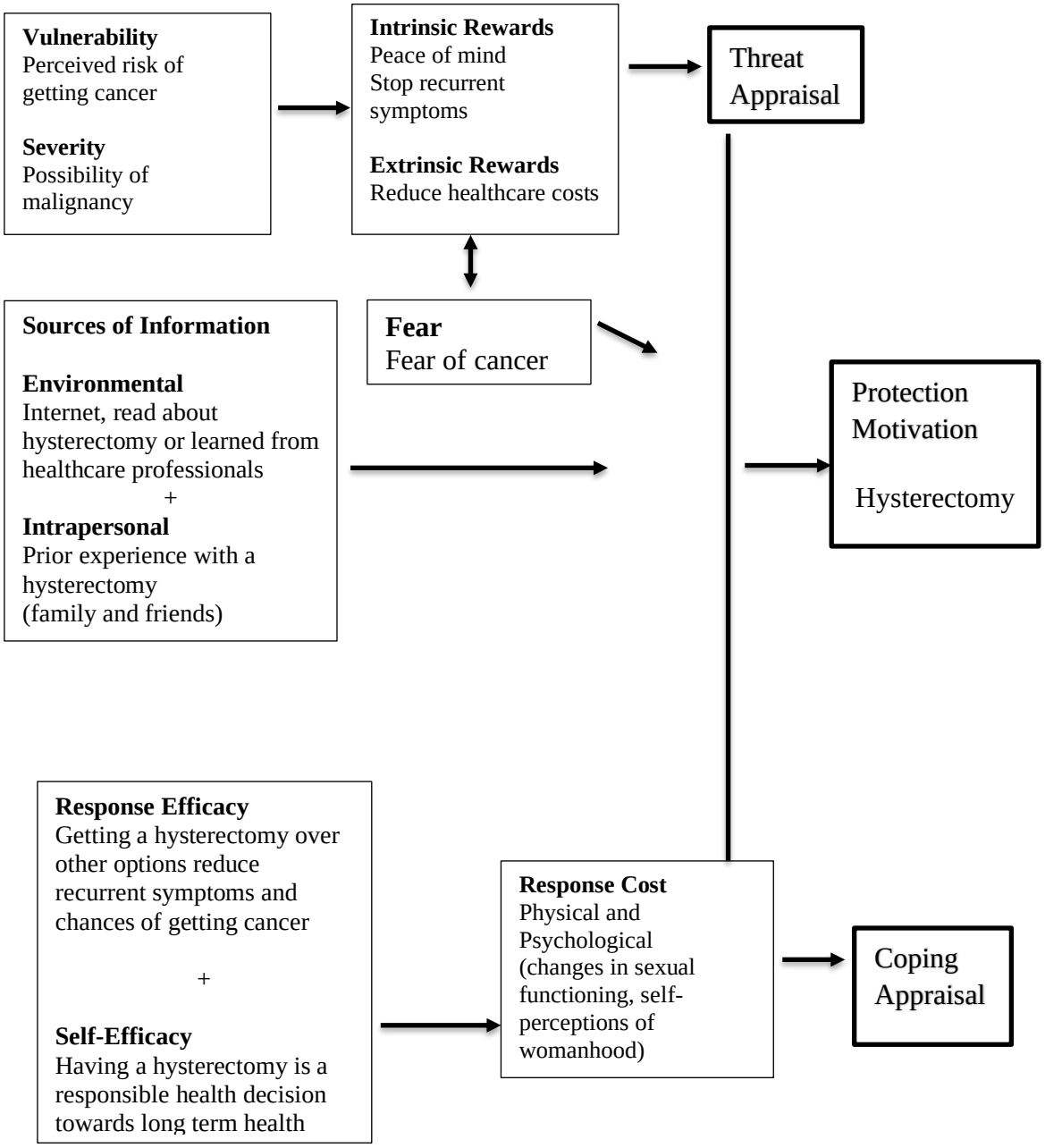

Figure 3.

Healthcare professional choice and presurgical visits