FEATURES OF THE FORMATION OF PSYCHO-EMOTIONAL DISORDERS AND IDENTITY CRISIS IN PATIENTS WITH TUMORS OF THE REPRODUCTIVE SYSTEM AFTER HYSTERECTOMY

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INTRODUCTION

Among somatic diseases accompanied by psycho-emotional disorders, the specific share of pathology of the female reproductive system is probably the largest [1–4]. In the association of mental and gynecological disorders, it is difficult to determine the root cause, since the nervous, endocrine and immune systems are considered components of the general integration network that provides the adaptive capabilities of the organism [1]. Therefore, mental adaptation directly depends on the functioning of this system. On the other hand, stress can trigger a number of gynecological diseases – from infertility and benign proliferative processes to malignant neoplasms [3, 5, 6]. If the correction of hormonal imbalance in combination with psychological support is effective in the treatment of functional gynecological disorders, the treatment of neoplasms may require surgical intervention in the amount of hysterectomy. The last one, on the one hand, eliminates the disease, but on the other hand, it can be regarded by the patient as a loss of a symbol of femininity, gender identity, creating additional distress.

Back in the middle of the last century, researchers noted that depressive states occur after hysterectomy more often than after any other abdominal surgery [7]. In the 1970s, D.H. Richards formulated the concept of "posthysterectomy syndrome" [8], after which more and more clinical studies demonstrated that in women after hysterectomy more often develop psychoemotional disorders, such as insomnia, anxiety and depression, than those who have no hysterectomy [9–11]. The higher risk of depressive symptoms in the long term in women after hysterectomy did not depend on lifestyle or socioeconomic factors and was observed with the same frequency in the groups with and without oophorectomy [12]. The results of other studies have shown a higher incidence of depression after hysterectomies with oophorectomy than without it, due to benign uterine lesions [13]. Some patients find it difficult to perceive themselves in a new capacity after hysterectomy, because certain signs that symbolize gender identity are lost.

Objective of the study: to identify the frequency, structure and clinical manifestations of psychoemotional disorders and identity crises in women with benign tumors and malignant tumors of the female reproductive sphere after the surgical treatment that included at least hysterectomy, to substantiate the need and nature of treatment and rehabilitation measures.

MATERIALS AND METHODS

The study involved 75 patients who were inpatients at the Lviv Oncology Regional Diagnostic and Treatment Center from 2022 to 2024.

The age of the women ranged from 38 to 70 years. The average age of patients who underwent surgery was 53 years.

Patients were divided into 2 groups:

- group 1 – 53 women who had oncological diseases;
- group 2 – 22 women with benign tumors.

Both groups did not statistically differ in age and concomitant pathologies. All study participants underwent surgery.

Among patients with benign pathology, there were 18 patients with leiomyomas, two women with endometrial polyps resistant to progestin therapy, and two women with ovarian fibrothecomas. All patients with benign tumors underwent surgical treatment that included at least hysterectomy. All 53 patients with malignant tumors completed surgical or combined treatment for cancer. Among them were 18 patients with cervical cancer, 20 women with endometrial cancer, 15 women with ovarian cancer. In all patients, the component of surgical treatment was panhysterectomy.

The psychoemotional state of women was studied 6–12 months after the completion of surgical or combined (surgery + chemotherapy) treatment during a control visit to a gynecologist-oncologist. At the time of the visit, none of the cancer patients had signs of

cancer progression either during a gynecological examination or by radiographic imaging methods (CT, MRI). All patients were asked to assess their level of distress over the past week using the NCCN (National Comprehensive Cancer Network) Distress Thermometer, Ukrainian version 2.2022 [14], after explaining the purpose of the study. This single-item questionnaire uses a Likert scale from 0 (no problems) to 10 (extreme distress) and resembles a thermometer. It also includes a problem list updated by the NCCN working group. Patients assessed their level of distress over the past week. They also noted the problems that led to it: physical, emotional, social, spiritual/religious, and practical problems from the proposed list. The cut-off score, which determines the need for further examination and indicates the possible presence of psycho-emotional problems, is 4. Comfortable conditions were created for the patients to conduct the questionnaire, and they were not limited in time.

During statistical processing of data, the normality of distribution in groups was determined first. The nature of the distribution of the obtained variation series was checked using the Shapiro-Francia test, which confirmed the Gaussian nature of the data distribution. At statistical processing of the obtained data the arithmetic mean and its standard deviation (M ± SD) were calculated, relative values were analyzed, the probability of the difference between groups of patients was determined using the Student's t-test and chi-square test.

The participants of the study gave their consent to the use of clinical data and examination results for scientific purposes. The study was conducted in compliance with the Council of Europe Convention on Human Rights (04/04/1997) and the Declaration of Helsinki of the World Medical Association «Ethical principles of conducting scientific medical research involving human subjects» (1964–2013). The research process was reviewed and approved by the Bioethics Commission of the Danylo Halytskyi Lviv National Medical University (protocol No. 8 dated 10/12/2022).

RESULTS

The psychoemotional state of patients was assessed using the NCCN Distress Thermometer, depending on the nature of the tumor process (benign/malignant), for which a hysterectomy was performed. Before surgery, there was no significant difference between the groups in the average level of distress – 6.9 and 6.1 for groups 1 and 2, respectively (Fig. 1). After surgery for benign tumors, the average level of distress was relatively low – 3.9 ± 2; however, 15 (68%) of 22 women noted a value above the threshold ≥ 4 on the NCCN Distress Thermometer. Two patients defined their level of distress as 7 – the highest indicators for this group. It should be noted that, the level of distress above the threshold in the group of oncological patients was noted by 33 (66%) of 53 patients.

Among physical problems, a statistically significant difference between the groups was found in changes in eating behavior (11.3% in cancer patients and 8% in women with benign tumors) and in the frequency of tobacco use (7.5% and 5.3% for groups 1 and 2, respectively), which is demonstrated at Fig. 2.

Among emotional problems, sadness and depression were found in 37.7% of cancer patients, and in patients with benign

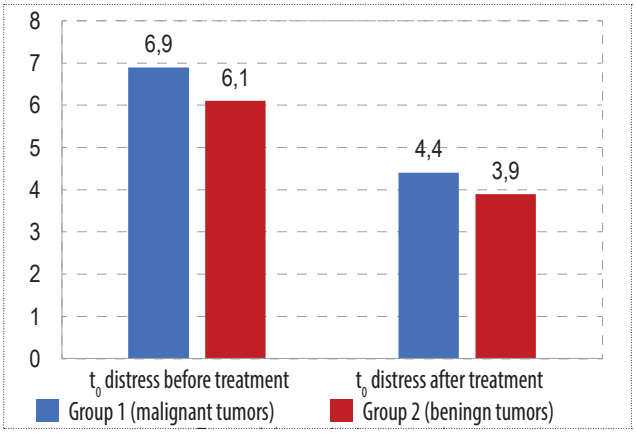

Figure 1. Indicators of the average level of distress in patients with malignant and benign tumors of the reproductive system before and after panhysterectomy

pathology only in 9.1% of cases (Fig. 3). Anhedonia with loss of interest in life or ability to receive pleasure was diagnosed in 17% of women with cancer. In 7.5% of cancer patients, a feeling of worthlessness or the awareness that they had become a burden to their loved ones was detected. At the same time, in patients with benign pathology after hysterectomies such complaints were not detected at all.

Every fifth patient (20.8%) in group 1 after hysterectomy experienced spiritual, ideological experiences, a change in the awareness of the meaning or purpose of life, and 7.5% of women were concerned about experiences, thoughts about death, and reflections on the possibility of life after death. Patients in group 2 did not have such experiences.

Patients with benign pathology also had no social problems (Fig. 4). At the same time, social problems were detected in 25% of cancer patients. After hysterectomy, women with malignant tumors had significantly higher levels of emotional problems (including sadness and depression, loss of interest or ability to enjoy things, loneliness, and feelings of worthlessness), social problems (relationships with children, family members, friends, or colleagues, communication with health care providers), and practical problems (work, caring for others, self-care, access to health care, adequate nutrition, child care, insurance, and education).

At the same time, patients with benign tumors showed the same high level of distress as women with cancer on indicators of physical problems, as well as a number of emotional, social, and practical problems.

Every tenth oncological patient had practical problems: 15.1% of patients faced problems in taking care of themselves; another 11.3% of women had problems in taking care of others (Fig. 5).

Therefore, the conclusion about the direct impact of the diagnosis of «cancer» on the formation of an identity crisis is obvious. An oncological diagnosis is a stigma that poses an existential challenge to a person regarding the meaning or purpose of life, the possibility of accepting the end of the life scenario.

It is noteworthy that the level of distress above the threshold was found in 68% of patients with benign uterine tumors who underwent hysterectomy. Thus, the loss of the organ that determines gender identity does not pass for a woman without trau-

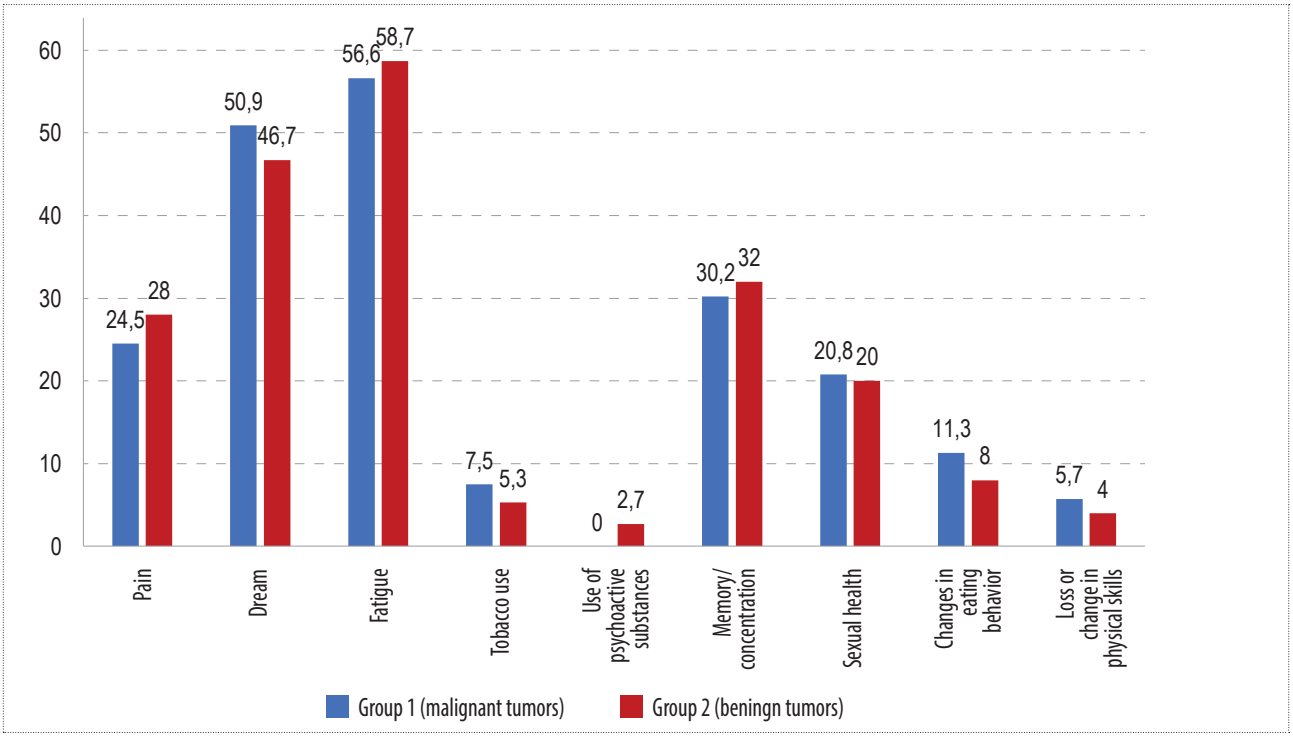

Figure 2. Physical problems in patients with malignant and benign tumors of the reproductive system after panhysterectomy, %

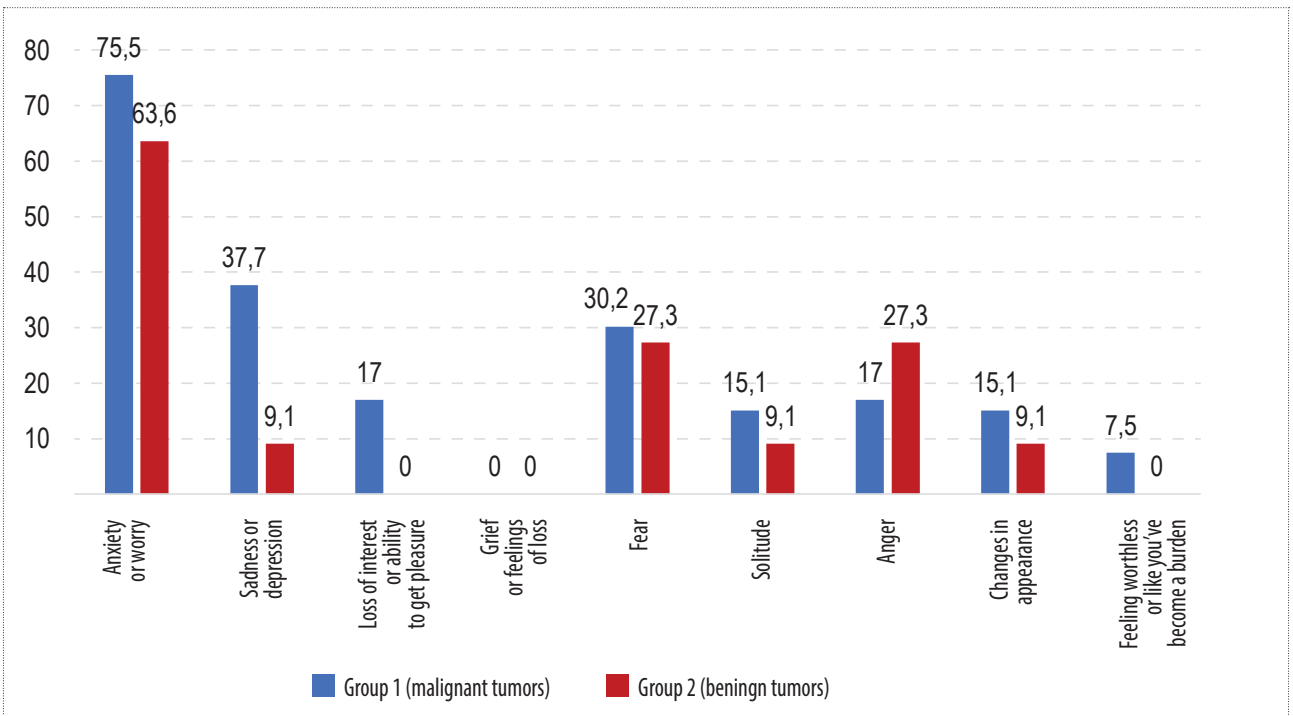

Figure 3. Emotional problems in patients with malignant and benign tumors of the reproductive system before and after panhysterectomy, %

matic psycho-emotional consequences. Memory impairment with concentration of attention was found somewhat more often in patients with benign pathology (32%), compared to cancer patients (30%), although the difference is not statistically significant. At the same time, outbursts of anger occurred in almost every fourth patient with benign uterine tumors (27%), compared to cancer patients (17%). In group 2, 68% of women had anxiety and worry, 27% of women had fear, 46% of women had sleep disorders, and every fifth patient had sexual problems. Almost every fifth patient after hysterectomy, even without cancer, noted problems in relationships with their partner.

Thus, it was found that although there was no statistically significant difference in the level of distress between the groups of women with malignant and benign tumors before surgery, af-

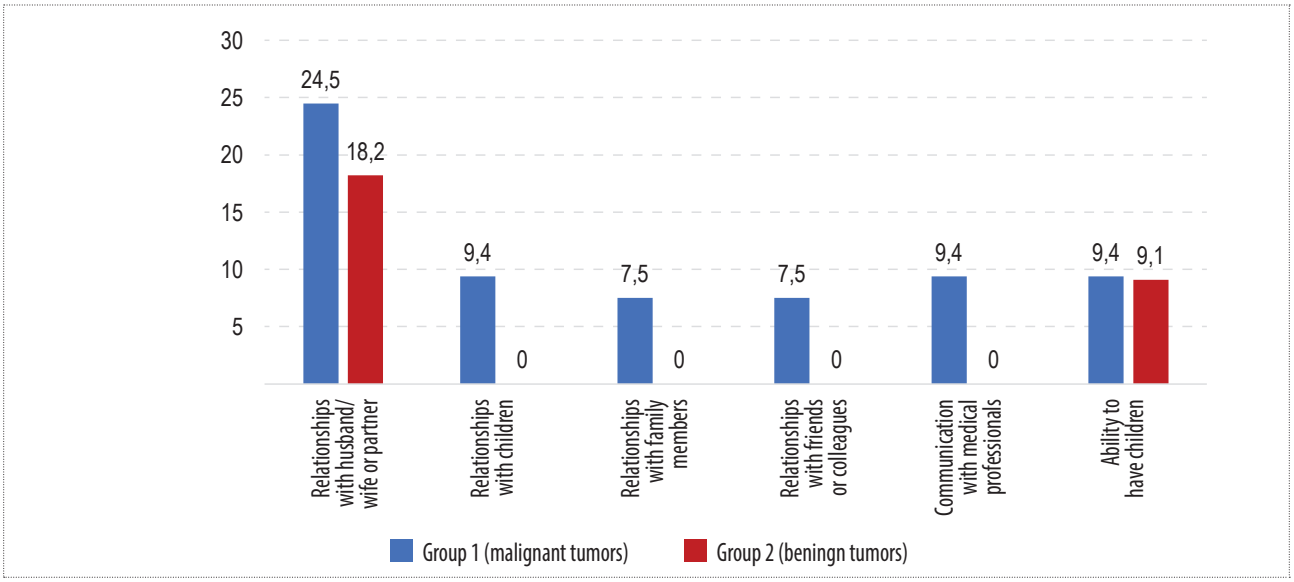

Figure 4. Social problems in patients with malignant and benign tumors of the reproductive system before and after panhysterectomy, %

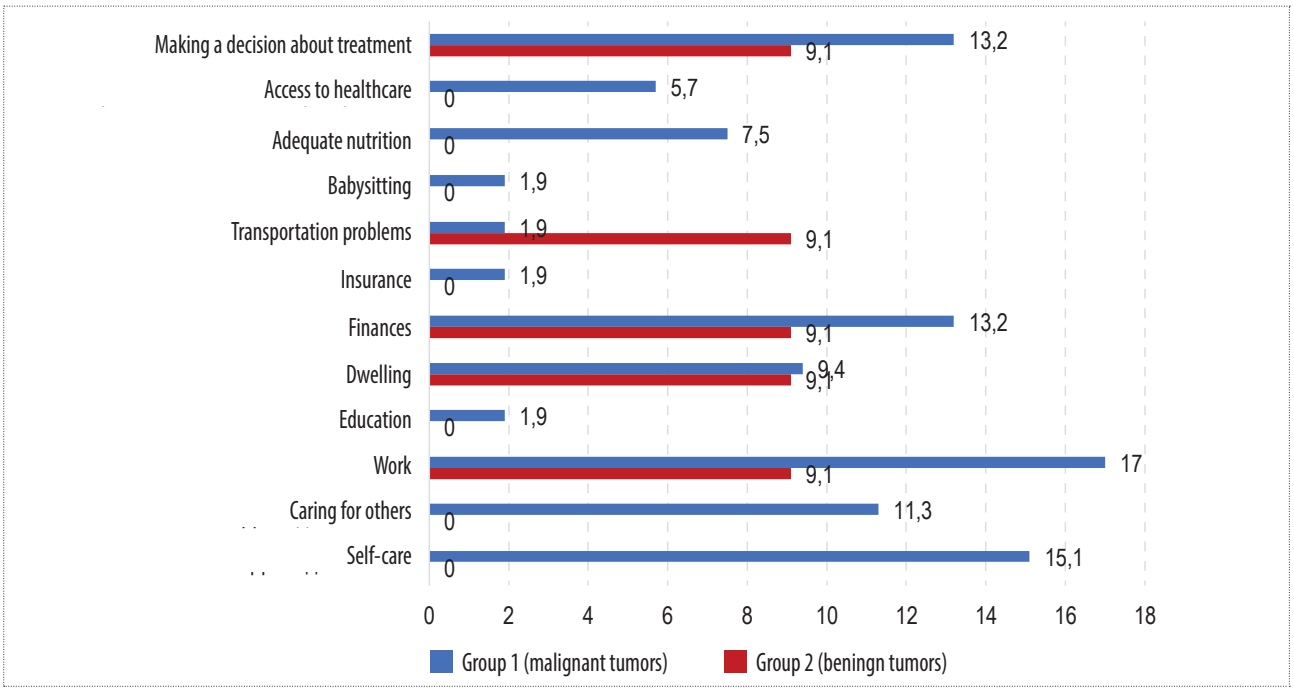

Figure 5. Practical problems in patients with malignant and benign tumors of the reproductive system before and after panhysterectomy, %

ter hysterectomy, the group of patients with malignant tumors had significantly higher levels of:

- emotional problems (in particular, according to the parameters of sadness and depression, loss of interest or ability to get pleasure, loneliness and feelings of worthlessness);
- social problems (relationships with children, family members, friends or colleagues, communication with medical professionals);
- practical problems (work, caring for others, self-care, access to health care, adequate nutrition, childcare, insurance and education).

In terms of physical, emotional, social, and practical problems, patients in group 2 demonstrated the same high level of distress as women in group 1.

Virtually none of the patients examined sought help on their own or were referred to a mental health specialist by their treating physician. After using the NCCN Distress Thermometer women with benign tumors who had a distress score above the threshold were consulted by a psychologist and, if necessary, a psychiatrist. All patients with a distress score of 4 or higher were consulted by a psychologist/psychiatrist. Two patients in group 2 and eight patients in group 1 were offered and started a course of psychotherapy, and medication was prescribed.

During the study, psychotherapeutic intervention in the psychoanalytic method, cognitive behavioral therapy, music therapy, and art therapy showed high effectiveness. If necessary,

psychodynamic work was combined with medication support. A significant contribution was made by psychosocial support, which is associated with the position of the family.

DISCUSSION

Studies of psychoemotional disorders in women who have undergone hysterectomy demonstrate rather contradictory data. A number of scientific works highlight the deterioration of mental health of one degree or another, caused by hysterectomy [14]. The most common symptom of posthysterectomy mental pathology is considered to be depression: the likelihood of its development increases with concomitant removal of the ovaries, as well as in the case of the need for postoperative hormone therapy [15]. At the same time, the risk of developing depressive symptoms persists for a long time – according to some data, up to 12 years from the moment of hysterectomy [16].

It is worth noting that depression is not the only manifestation of deterioration in mental well-being in women who have undergone hysterectomy – other symptoms of mental deviations include anxiety, decreased self-esteem, changes in body image, sexual dysfunction (decreased sexual desire and arousal, anorgasmia), feelings of social isolation and changes in the perception of one's own femininity [14, 17–19].

However, there is a large amount of evidence that depression and other psychoemotional disorders are not inevitable consequences of hysterectomy [20]. One study showed that women who experienced menopause induced by hysterectomy were not at greater risk of depression than women who experienced natural menopause [21]. Other studies indicate that women with a history of depressive episodes are more likely to develop depression after hysterectomy, while patients without a history of psychiatric disorders have a risk of developing depression that is either statistically no different from the general population or is minimally increased; however, depressive symptoms usually develop later and are not the result of the surgery itself, but of its sociobiological consequences, most often the inability to have children, which is a significant psychological trauma for women of reproductive age [22–24]. However, in some cases, the surgery itself can trigger an identity crisis that the woman is unable to overcome. In an environment where social and cultural norms closely link a woman's identity and self-esteem with her reproductive health, the psychological impact may be even more pronounced [25]. It is not easy to determine which of the operated patients is facing a similar problem and needs special help. Not all surgical and gynecological departments have psychologists, and if they are, they do not actively identify patients with psychoemotional disorders.

The NCCN Distress Thermometer questionnaire, proposed by the attending physician, who is not a specialist in the field of mental health, but with whom a relationship of trust has already been formed, turned out to be a convenient screening tool for identifying psychoemotional disorders and a reason for referring oncological gynecological patients to a specialist [26]. At the same time, the results of our study indicate its effectiveness for other categories of patients.

Thus, it becomes obvious that surgical intervention, which is accompanied by the loss of the central organ of reproduction due to hysterectomy, can be an important factor contributing to the development of an identity crisis, the consequences of which can be mental health disorders with varying degrees of clinical manifestation.

Unfortunately, the aspect of supporting the mental health of women with such problems is not given due attention. On the one hand, there is a lack of psycho-educational, diagnostic and correctional and rehabilitation efforts of medical workers. On the other hand, the problem lies in the independent appeal of patients about their psycho-emotional problems, which, in turn, may be due to «cultural stigma». In other words «it is embarrassing to talk about it». As a result, this problem remains ignored, hushed up, does not receive due attention, and accordingly has no chance of being solved.

Psycho-education, early screening diagnostic interventions and provision of medical care at the primary level (family doctors, gynecologists) could become measures to prevent and correct mental problems. Consultation by specialists (psychologists, psychotherapists, psychiatrists) and, if necessary, proper support of the woman on the path of her transformation, search for new meanings and values would allow overcoming the identity crisis, would contribute to the correction of posthysterectomy psychoemotional disorders.

CONCLUSIONS

The obtained results of the study allow us to formulate the following conclusions:

1. The level of distress above the threshold and psychoemotional disorders indicating an identity crisis were detected in the majority of patients after successful surgical treatment that included at least hysterectomy: both in patients with malignant tumors of the reproductive system (66%), and in women with benign pathology (68%).

2. There is an obvious need for active screening to assess the level of distress, identify psychoemotional disorders and identity crisis after hysterectomies not only in women with malignant tumors, but also in patients with benign neoplasms of the reproductive system.

3. The NCCN Distress Thermometer questionnaire can be used for screening purposes to determine the level of distress not only in cancer patients, but also in patients with benign pathology of the reproductive system.

Conflict of interest

There is no conflict of interest.

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ОСОБЛИВОСТІ ФОРМУВАННЯ ПСИХОЕМОЦІЙНИХ РОЗЛАДІВ ТА КРИЗИ ІДЕНТИЧНОСТІ У ХВОРИХ ІЗ ПУХЛИНАМИ РЕПРОДУКТИВНОЇ СИСТЕМИ ПІСЛЯ ГІСТЕРЕКТОМІЇ

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Мета дослідження: вивчення частоти та рівня дистресу, структури, клінічних проявів психоемоційних розладів та кризи ідентичності в жінок із доброякісними новоутвореннями та злоякісними пухлинами жіночої репродуктивної системи після завершення хірургічного лікування в об'ємі щонайменше гістеректомії.
Матеріали та методи. Дослідження охоплювало 75 жінок віком від 38 до 70 років, яким було проведено гістеректомію, із них 53 особи – зі злоякісними пухлинами жіночої репродуктивної системи (група 1) та 22 особи – з доброякісними пухлинами (група 2). Усім пацієнткам для визначення рівня дистресу та виявлення психоемоційних розладів до та після перенесеного хірургічного лікування було проведено опитування з використанням NCCN-дистрес-термометра, української версії 2.2022.
Результати. Отримані в ході дослідження дані засвідчили, що хоча до хірургічного втручання не було статистично значущої різниці в рівні дистресу між групами жінок зі злоякісними та доброякісними пухлинами, після гістеректомії в групі хворих зі злоякісними пухлинами відмічався вірогідно вищий рівень емоційних проблем (зокрема, за параметрами наявності смутку та депресії, втрати інтересу або здатності отримувати задоволення, самотності та відчуття нікчемності), соціальних проблем (стосунки з дітьми, членами сім'ї, друзями або колегами, комунікація з медичними працівниками), а також проблем практичного характеру. Водночас за показниками проблем фізичного характеру, а також низки проблем емоційного, соціального та практичного характеру пацієнтки з доброякісними пухлинами продемонстрували такий же високий рівень дистресу, як і пацієнтки зі злоякісними пухлинами.
Висновки. Результати дослідження дають змогу зробити висновки про необхідність активного скринінгу для оцінки рівня дистресу. Психоемоційні розлади та кризи ідентичності після гістеректомій були виявлені не тільки в групі пацієнток зі злоякісними пухлинами, але й у жінок із доброякісними новоутвореннями репродуктивної системи. Як інструмент такого скринінгу може бути використаний опитувальник NCCN-дистрес-термометр.

Ключові слова: криза ідентичності, пухлини жіночої репродуктивної системи, гістеректомія, психоемоційні розлади, NCCN-дистрес-термометр.

FEATURES OF THE FORMATION OF PSYCHO-EMOTIONAL DISORDERS AND IDENTITY CRISIS IN PATIENTS WITH TUMORS OF THE REPRODUCTIVE SYSTEM AFTER HYSTERECTOMY

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Objective of the study: to evaluate the psychoemotional condition in patients with benign and malignant tumors of the reproductive system after hysterectomy and successfully completed treatment.
Materials and methods. The study included 75 women aged 38 to 70 years who had undergone hysterectomy, including 53 women with malignant tumors of the female reproductive system (group 1) and 22 women with benign tumors (group 2). All patients were surveyed using the NCCN Distress Thermometer (Ukrainian version 2.2022) to determine the level of distress and identify psychoemotional disorders before and after surgical treatment.
Results. The data obtained during the study allowed to establish that although before the surgical intervention was no statistically significant difference in the level of distress between the groups of women with malignant and benign tumors, after hysterectomy in the group of patients with malignant tumors was noted a significantly higher level of emotional problems (in particular, according to the parameters of the sadness and depression, loss of interest or ability to get pleasure, loneliness and feelings of worthlessness), social problems (relationships with children, family members, friends or colleagues, communication with medical professionals), as well as practical problems. At the same time, according to indicators of physical problems, as well as a number of emotional, social and practical problems, patients with benign tumors demonstrated the same high level of distress as patients with malignant tumors.
Conclusions. The results of the study allow us to draw conclusions about the need for active screening to assess the level of distress. The presence of psychoemotional disorders and identity crises after hysterectomies was evident not only in the group of patients with malignant tumors, but also in women with benign tumors of the reproductive system. NCCN Distress Thermometer can be used for the purpose of such screening.

Keywords: identity crisis, tumors of the female reproductive system, hysterectomy, psychoemotional disorders, NCCN Distress Thermometer.