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Research Paper

Prevalence of Depressive Symptoms Among Women Who Had Hysterectomy in India: Evidence from Lasi

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ABSTRACT

Hysterectomy, the surgical removal of the uterus, is a common gynaecological procedure performed to treat various conditions, including uterine cancer, fibroids, endometriosis and pelvic organ prolapse. It has a significant impact on women's health and quality of life. This study aims to understand the prevalence of depression among women who had hysterectomy (45 above) by their demographic and socio-economic characteristics. This study used data from Longitudinal Ageing Survey of India (LASI) conducted during the year 2017-18. For the present study, 3649 is the sample size. Univariate and bivariate analysis were used to analyse various demographic, socio-economic characteristics of women who had hysterectomy and also the prevalence of depression among women who had hysterectomy. In addition to that, Chi-square and Logistic Regression were also used for the analysis. Depressive symptoms were measured using the CES-D scale (Centre for Epidemiologic Studies Depression Scale). The whole analysis is done by using SPSS package. In the study sample, it can be observed that the prevalence of depression among women who had undergone hysterectomy is 28.1 per cent. i.e., nearly one-fourth of women who had their uterus surgically removed experience symptoms of depression. Depressive symptoms after hysterectomy in India are influenced by hormonal, psychological, physical, and socio-cultural factors. Risk factors like age, mental health conditions, and social support contribute to distress. A holistic approach that integrates medical care, psychological counselling, and social support is essential to address these complexities, enabling tailored interventions to promote the mental well-being of women undergoing this life-altering procedure.

Keywords: *Hysterectomy, Depression, CES-D scale*

Hysterectomy is a surgical procedure that involves the removal of the uterus, the female reproductive organ where a foetus develops during pregnancy. The term hysterectomy originates from two Greek words: "hystero" which means uterus and "ectomy" which means resection removal from the human body (Papadopoulos et al., 2010). Hysterectomy, the surgical removal of uterus, is the second most frequently performed non-obstetric surgery after caesarean section in many parts of the world. It had border socio-economic, demographic and medical phenomenon (Prusty et al., 2018). Hysterectomy has traditionally been considered the method of choice for treating a variety of benign

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gynaecological disorders due to the low perioperative morbidity and definite cure of these diseases (Carlson et al., 1993). Hysterectomy artificially ends the reproductive function and has several positive and negative effects on women's physical and psychosocial health (Singh et al., 2021). It is a significant procedure that causes morbidity and the beginning of menopausal symptoms in females. Existing evidence suggests that age at menarche, age at first birth and parity may all be associated with subsequent hysterectomy risk (Cooper et al., 2008). Knowledge regarding hysterectomies in India is limited, partly due to lack of information from large scale national representative surveys (Shekhar et al., 2019). Women's health in middle and later life undergoes several changes related to the reproductive system; changes such as menopause (hot flashes, moodiness, headaches, and trouble sleeping), vaginal dryness, urinary tract changes osteoporosis etc. can have significant health implications (NIH, 2018). In India, the prevalence of hysterectomy, premature menopause, and cervical cancer is rising (Jungari and Chauhan, 2017).

In India, the prevalence of hysterectomy operation is 3.3 per cent among women aged 15-49 years as per the study based on fifth National Family Health Survey (NFHS 5) for the year 2019-21. There is a marginal increase from NFHS 4, which recorded a rate of 3.2 per cent. LASI (2017-18) shows that 11 per cent of older adult women age 45 and above in India reported having undergone hysterectomy. Variation in hysterectomy rates have been associated with women's demographic characteristics such as race, education and socio-economic status and insurance status, as well as their physician's gender, training and geographical location, suggesting that the procedure is related to the broader social and health system environment as well as to biological risk (Gimbel et al., 2002; Materia et al., 2002). The majority of hysterectomies are performed on benign reasons in order to increase quality of life; nevertheless, it can bring about some post-operative long-term problems such as depression, sexual dysfunction and especially, urine incontinence (Goktas et al., 2015). Among them depression symptoms are most common. In addition, depending on the lack of uterus among women after hysterectomy and the termination of the capacity of reproduction, the anxiety for no longer having any sex increases the risk of depression, having an impact on the thoughts, social life and partnering communication of women focusing too much on reproduction (Farooqi,2005). The relationship between hysterectomy and depressive symptoms is complex and multifaceted. Undergoing a hysterectomy has a strong effect on a woman's sexuality, causing poor body image and other factors which could lead to depression (Asgharnia and Esmailpoor, 2008). Women often consider the uterus to be a sexual organ, and the controller and regulator of important physiological functions in the body, as well as the source of youth, energy, activity and a symbol of child bearing capacity (Alipour and Pour, 2010).

Mental health is an integral part of health and well-being of older adults (WHO, 2013). Depression is defined as an extended period of time (at least two weeks) in which a person experiences a depressed mood or loss of interest or pleasure in activities that were once enjoyed (Gururaj et al., 2016). Depression can cause great suffering and can lead to impaired functioning in daily life. Healthcare professionals should be vigilant in assessing and monitoring the mental health of women both before and after a hysterectomy, offering appropriate support and interventions as needed.

Increasing number of hysterectomies raises public health concerns, as they can cause physical, sexual, and psychological problems for women. Among them, depressive symptoms are most common. Depression significantly affects a person's well-being and

quality of life. For women undergoing hysterectomy, experiencing depression can intensify feelings of sadness, loss and emotional distress related to the removal of a reproductive organ.

Objectives of the Study

- To understand the demographic and socio-economic characteristics of women who had undergone hysterectomy.
- To understand the prevalence of depression among women who had hysterectomy (45 above) by their demographic and socio-economic characteristics.

Data

This study used data from Longitudinal Ageing Survey of India (LASI) conducted during the year 2017-18. The LASI is a full-scale national survey of scientific investigation of the health, economics and social determinants and consequences of population ageing in India. The LASI is a nationally representative survey of 72,250 older adults out of which 30,569 are males and 41,681 are females. This study provides sufficient statistical information required to test hypotheses in subpopulations of interest. For the present study, 3649 is the sample size (i.e., women who had hysterectomy above 45 years age).

METHODOLOGY

In this study, univariate and bivariate analysis are used to analyse various demographic, socio-economic and health characteristics of women who had hysterectomy and also the prevalence of depression among women who had hysterectomy.

This study also examines the depression levels in woman after hysterectomy by analysing their responses to various questions. The depressive symptoms are measured by using a scale called CES-D (Centre for Epidemiologic Studies Depression Scale). The original CES-D scale is a 20-item scale, while a shortened 10-item scale with four scale option categories was used in the LASI. The 10 items included seven negative symptoms (trouble concentrating, feeling depressed, low energy, fear of something, feeling alone, bothered by things, and everything is an effort), and three positive symptoms (feeling happy, hopeful, and satisfied). Response options included rarely or never (<1 day), sometimes (1 or 2 days), often (3 or 4 days), and most or all of the time (5-7 days) in a week prior to the interview. For negative symptoms, rarely or never (<1 day), and sometimes (1 or 2 days) were scored zero, and often (3 or 4 days) and most or all of the time (5-7 days) categories were scored one. Scoring was reversed for positive symptoms. The overall score ranges from zero to 10 and score of four or more are used to calculate the prevalence of depressive symptoms.

In addition to univariate and bivariate analysis, Chi-square and Logistic Regression are also used for the analysis. The whole analysis is done by using SPSS package.

Prevalence of Hysterectomy among Women by Various Background Characteristics

The Table 1 shows the prevalence of hysterectomy among women (45 above) by their background characteristics in India. The prevalence of hysterectomy among women aged 45 and above is highest in the 50-59 age group (11.7 per cent), followed by 60-69 years (10.7 per cent), 45-49 years (10.5 per cent), 70-79 years (8.4 per cent) and 80+ years (5.6 per cent). Urban women (11.7 per cent) report higher rates than rural women (9.8 per cent). By religion, women from other religious groups (16.6 per cent) are more likely to undergo hysterectomy compared to Hindus (11.2 per cent), Christians (6.9 per cent) and Muslims

(6.7 per cent). OBC women (12.2 per cent) report higher rates than Scheduled Castes (11.1 per cent), other groups (11.1 per cent) and Scheduled Tribes (5 per cent). Education influences rates, with primary-educated women (12.4 per cent) slightly ahead of those with secondary (12 per cent), higher education (10.7 per cent), and illiterates (9.5 per cent). Currently married women or those living with a partner (11.6 per cent) have higher rates compared to widowed (8.7 per cent), divorced/separated (6.9 per cent) and never-married women (4.4 per cent). Women living with a spouse and others (12.8 per cent) report the highest rates by living arrangement, while those living with others only (6.5 per cent) have the lowest. Non-working women (11 per cent) are more likely to have had a hysterectomy than employed women (9.6 per cent). Economic status shows a gradient, with the richest women (14.1 per cent) having the highest rates, followed by richer (12 per cent), middle (10.1 per cent), poorer (8.7 per cent), and the poorest women (7.3 per cent).

Table 1 Prevalence of Hysterectomy among Women by Various Background Characteristics

Variables	**Categories**	**Percentage of women who had hysterectomy**
AGE	45-49	10.5
	50-59	11.7
	60-69	10.7
	70-79	8.4
	80+	5.6
PLACE OF RESIDENCE	Rural	9.8
	Urban	11.7
RELIGION	Hindu	11.2
	Muslims	6.7
	Christians	6.9
	Others	16.6
CASTE	SC	11.1
	ST	5
	OBC	12.2
	Others	11.1
EDUCATION	Illiterate	9.5
	Primary	12.4
	Secondary	12
	Higher	10.7
MARITAL STATUS	Currently married/with partner	11.6
	Widowed	8.7
	Never married	4.4
	Divorced/Separated/Deserted	6.9
LIVING ARRANGEMENT	Living alone	9.7
	Living with spouse and/or others	12.8
	Living with spouse and children	11.3
	Living with children and others	8.8
	Living with others only	6.5
OCCUPATION	Yes	9.6
	No	11
MPCE QUINTILE	Poorest	7.3
	Poorer	8.7
	Middle	10.1
	Richer	12

Variables	Categories	Percentage of women who had hysterectomy
	Richest	14.1
Total		3649

Depression in women who had hysterectomy in India

Table 2 shows the association of depression symptoms among women who had hysterectomy in India according to LASI 2017-18. In the study sample, it can be observed that the prevalence of depression among women who had undergone hysterectomy is 28.1 per cent and about 72 per cent of women who had hysterectomy have no depressive symptoms. These findings indicate that nearly one-fourth of women who had their uterus surgically removed experience symptoms of depression. 27 per cent of women who do not undergone hysterectomy have depressive symptoms. From this, we can understand that depression is slightly more common in women who had hysterectomy than in women who have not.

Table 2 Association of Depression Symptoms among Women who had Hysterectomy

	DEPRESSION OF THE RESPONDENT		CHI SQUARE VALUE
HYSTERECTOMY* **	**Yes**	**No**	
Yes	28.1	71.9	
No	27.3	72.7	174.232

*(Significant level if (P<0.01=***))*

Prevalence of Depression Symptoms among Women (45 above) who undergone Hysterectomy by Indian states and Union Territories

The Table 3 shows the prevalence of depression among women (45 above) who had undergone hysterectomy by Indian states and Union Territory. In India, 28.1 per cent of women who had hysterectomy experience depression. Regional wise distribution across the nation shows that the prevalence of depression among women who had hysterectomy is high in the central region of India (i.e., 38 per cent) followed by 31.8 per cent from eastern India, 31.5 per cent from southern India, 25.4 per cent in northern India, 20.1 per cent in western India and the lowest among all is in the north eastern India (i.e., 14 per cent). The highest percentage of depression among women who had hysterectomy is in Delhi (i.e., 49.4 per cent) followed by Madhya Pradesh (45.1 per cent), Karnataka (44.8 per cent), Jammu & Kashmir (42.1 per cent), Bihar (41 per cent) and the prevalence of depression was lowest in Meghalaya (0 per cent) and Nagaland (0 per cent) followed by Manipur (5 per cent), Arunachal Pradesh (11.1 per cent), Chandigarh (13.5 per cent), Punjab (16.4 per cent).

Table 3 State wise Prevalence of Depression Symptoms among Women who had Hysterectomy

STATES/UNION TERRITORY	DEPRESSION (%)
INDIA	**28.1**
NORTH	**25.4**
JAMMU & KASHMIR	42.1
HIMACHAL PRADESH	24
PUNJAB	16.4
CHANDIGARH	13.5
UTTARAKHAND	27
HARYANA	35.5

STATES/UNION TERRITORY	DEPRESSION (%)
DELHI	49.4
RAJASTHAN	22.9
CENTRAL	**38**
UTTAR PRADESH	39.3
CHHATTISGARH	26.5
MADHYA PRADESH	45.1
EAST	**31.8**
BIHAR	41
JHARKHAND	21.4
ODISHA	19
WEST BENGAL	31.1
NORTH EAST	**14**
ARUNACHAL PRADESH	11.1
ASSAM	18.2
MANIPUR	5
MEGHALAYA	0
MIZORAM	22.7
NAGALAND	0
TRIPURA	26.1
WEST	**20.1**
DADRA AND NAGAR HAVELI	34.7
DAMAN AND DIU	22.7
GUJARAT	19.8
MAHARASHTRA	16.5
GOA	17.8
SOUTH	**31.5**
ANDHRA PRADESH	29.2
TELANGANA	30.3
KARNATAKA	44.8
KERALA	24.5
LAKSHADWEEP	19.2
PUDUCHERRY	36.5
TAMIL NADU	35.2
ANDAMAN AND NICOBAR ISLANDS	23.8

Figure 1 Regional wise distribution of prevalence of depression among women who had hysterectomy by Indian States/UT

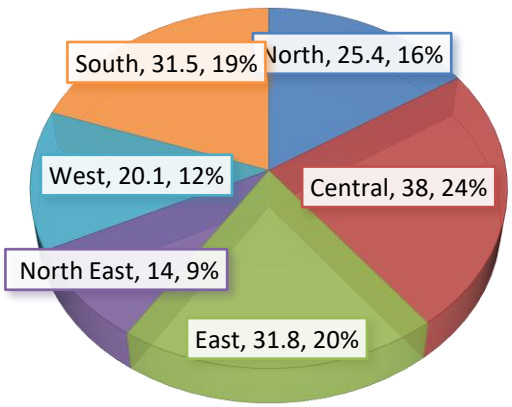

Table 4 Percentage Responses to Various Items selected for Measuring Depression among Women who had Hysterectomy

DEPRESSIVE SYMPTOMS	PERCENTAGE	
	YES	NO
How often did you have trouble in concentrating?	13.2	86.8
How often did you feel depressed?	14.8	85.2
How often did you feel tired/low in energy?	25.1	74.9
How often were you afraid of something?	9.7	90.3
How often did you feel alone?	13.2	86.8
How often were you bothered by things that don't usually bother you?	19.1	80.9
How often did you feel that everything you did was an effort?	19.1	80.9
How often did you feel you were overall satisfied?	64.7	35.3
How often did you feel hopeful about the future?	64.3	35.7
How often did you feel happy?	47.4	52.6

Table 4 shows the percentage of responses to various items for measuring depression symptoms among woman who had hysterectomy. In the sample it was found that about 13.2 per cent women have trouble in concentrating. Around 15 per cent reported that they were feeling depressed most of the time. 25.1 per cent women reported that they have feeling tired or they lost their energy. Around 10 per cent of women are afraid of doing something. About 13.2 per cent of women reported that most of the time they are feeling alone. About 19.1 per cent of women reported that they are bothered by things that don't usually bother them. Around 19 per cent also feel that everything they did were an effort exerted. About 35.3 per cent women are not feeling satisfied. About 35.7 per cent women who had hysterectomy mentioned that they are not feeling hopeful in their life. More than half of the women (i.e., 52.6 per cent) are not feeling happy.

Prevalence of Depression among Women (45 above) who had Hysterectomy (45 above) by their Background Characteristics in India, LASI 2017-18

The Table 5 shows the prevalence of depression among women (45 above) who had hysterectomy by their background characteristics in India. The prevalence of depression among women aged 45 and above who have undergone hysterectomy varies across age, residence, caste, religion, education, marital status, living arrangements, employment, and economic status.

Women aged 70-79 years report the highest prevalence (31.8 per cent), followed by those aged 80+ years (31.6 per cent), while younger age groups have slightly lower rates. Depression is more common among rural women (29.7 per cent) compared to urban women (25.7 per cent). Muslim women (32.9 per cent) have a higher prevalence than Hindus (29 per cent), Christians (20.8 per cent), and other religious groups (20 per cent). By caste, women from the OBC category (30.7 per cent) report higher prevalence compared to Scheduled Castes (30.5 per cent), Scheduled Tribes (23.3 per cent), and other groups (24.3 per cent). Depression is also strongly linked to education, with rates decreasing from 31 per cent among uneducated women to 17.3 per cent for those with higher education. Never-married women show the highest prevalence (43.8 per cent), followed by divorced/separated (34.1 per cent), widowed (32.3 per cent), and currently married women (26.3 per cent). Living

arrangements also matter, with women living with others only (38.9 per cent) or alone (36.7 per cent) reporting higher prevalence than those living with spouse and children (25.7 per cent). Unemployed women (32.5 per cent) show higher rates than employed women (28.3 per cent). Economically, depression is most prevalent among the poorest women (33.9 per cent) and declines with increasing wealth, with the richest women reporting 25 per cent.

Table 5 Association of Depression among Women who had Hysterectomy by their Background Characteristics

VARIABLES	**CATEGORIES**	**PERCENTAGE**		**CHI SQUARE**
		YES	**NO**	
AGE	45-49	28	72	3.462
	50-59	27.4	72.6	
	60-69	27.5	72.5	
	70-79	31.8	68.2	
	80+	31.6	68.4	
PLACE OF RESIDENCE***	Rural	29.7	70.3	6.751
	Urban	25.7	74.3	
RELIGION***	Hindu	29.1	70.9	19.471
	Muslims	32.9	67.1	
	Christians	20.8	79.2	
	Others	20	80	
CASTE***	SC	30.5	69.5	18.191
	ST	23.3	76.7	
	OBC	30.7	69.3	
	Others	24.3	75.7	
EDUCATION***	Illiterate	31	69	28.255
	Primary	27.4	72.6	
	Secondary	22.5	77.5	
	Higher	17.3	82.7	
MARITAL STATUS***	Currently married/with partner	26.3	73.7	15.246
	Widowed	32.3	67.7	
	Never married	43.8	56.3	
	Divorced/Separated/Deserted	34.1	65.9	
LIVING ARRANGEMENT***	Living alone	36.7	63.3	19.534
	Living with spouse and/or others	28.5	71.5	
	Living with spouse and children	25.7	74.3	
	Living with children and others	30.3	69.7	
	Living with others only	38.9	61.1	
OCCUPATION*	Yes	28.3	71.7	3.687
	No	32.5	67.5	
MPCE QUINTILE***	Poorest	33.9	66.1	18.063
	Poorer	31.5	68.5	
	Middle	28.1	71.9	
	Richer	25	75	
	Richest	25.8	74.2	

(Significant level if (P<0.1=) and (P<0.01=***))*

Table 6 Logistic regression examining the effect of background characteristics in women (45 above) who had hysterectomy, LASI 2017-18

CHARACTERISTICS	**Exp β**
PLACE OF RESIDENCE	
Rural ®	
Urban	0.853
RELIGION	
Hindu ®	
Muslims	1.410
Christians	0.837
Others	0.717
CASTE	
SC ®	
ST***	0.540
OBC	0.815
Others***	0.604
EDUCATION	
Illiterate ®	
Primary	1.018
Secondary	0.844
Higher**	0.513
MARITAL STATUS	
Currently married/with partner ®	
Widowed	1.799
Divorced/Separated/Deserted	1.402
Never Married	1.632
LIVING ARRANGEMENT	
Living alone ®	
Living with spouse and/or others	1.409
Living with spouse and children	1.071
Living with children and others	0.788
Living with others only	1.257
OCCUPATION	
Yes ®	
No**	1.311
MPCE QUINTILE	
Poorest ®	
Poorer	1.029
Middle	0.899
Richer	0.762
Richest	0.805

*(Significant level if (P<0.05=**), (P<0.01=***))*

Table 6 shows the odds ratio of logistic regression analysis explaining the effect of background characteristics on depression among women (45 above) who had hysterectomy. The dependent variable is depression (yes=1, no=0) and the independent variables selected are place of residence, religion, caste, education, marital status, living arrangement, occupation and MCPE quintile.

Women's likelihood of experiencing depression varies significantly based on residence, religion, caste, education, marital status, living arrangements, employment and economic

status. Urban women who have had hysterectomies are 15 per cent less likely to suffer depression than their rural counterparts. Among religions, Muslim women have a 41 per cent higher risk, while Christians and other religious groups are 16 per cent and 28 per cent less likely, respectively, compared to Hindu women. Scheduled Tribe women are 46 per cent less likely, Other Backward Classes 18 per cent less likely, and others 39 per cent less likely to have depression compared to Scheduled Caste women. Education reduces depression risk, with higher educated women being 49 per cent less likely than illiterates, while primary education offers minimal impact. Widowed women face an 80 per cent higher risk, followed by never married (63 per cent) and divorced/separated (40 per cent) women, compared to married women. Women living alone have the highest risk, while those living with children and others are 21 per cent less likely to have depression. Unemployed women are 31 per cent more likely to suffer depression compared to employed women. Economic status also influences risk, with richer women significantly less likely to experience depression than the poorest women.

CONCLUSION

The prevalence of depressive symptoms among women following hysterectomy is a significant and multifaceted healthcare issue in India, shaped by a combination of hormonal, psychological, physical, and socio-cultural factors. Hysterectomy, commonly performed for conditions such as uterine fibroids, endometriosis, pelvic inflammatory disease, or cancer, often results in profound hormonal changes and emotional distress. The uterus, beyond its reproductive role, contributes to hormonal balance and overall well-being; its removal can lead to psychological challenges, including feelings of loss, grief, and a diminished sense of femininity.

In India, where societal and cultural norms closely tie a woman's identity and self-esteem to her reproductive health, the psychological impact can be even more pronounced. Additionally, the physical recovery process, marked by pain, fatigue, and changes in daily functionality, may exacerbate feelings of frustration, helplessness, and isolation, further contributing to depressive symptoms. Factors such as age, pre-existing mental health conditions, and the presence of robust social support systems significantly influence the likelihood of developing depression. Effective management of these challenges requires a comprehensive approach that integrates medical care, psychological counselling, and social support. Open communication with healthcare providers, mental health professionals, and support groups is vital for addressing concerns, learning coping strategies, and fostering emotional resilience. By addressing the intricate interplay of these factors, tailored interventions can be designed to promote the mental and emotional well-being of women undergoing this life-altering procedure.

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Conflict of Interest

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