

1

“To Have and Have Not”

Perspectives on Hysterectomy and Oophorectomy

Everyone in me is a bird.
I am beating all my wings.
They wanted to cut you out
but they will not.
They said you were immeasurably empty
but you are not.
They said you were sick unto dying
but they were wrong.

You are singing like a school girl.
You are not torn.
Sweet weight,
in celebration of the woman I am
and of the soul of the woman I am
and of the central creature and its delight
I sing for you. I dare to live.
Hello, spirit. Hello, cup.
Fasten, cover. Cover that does contain.
Hello to the soil of the fields.
Welcome, roots . . .

—Anne Sexton, “In Celebration of My Uterus”

THESE LINES celebrate the poet’s relief at discovering that she will not have to undergo hysterectomy, the surgical removal of her uterus. The rest of the poem celebrates womanhood in many forms. Appropriately included in a collection entitled *Love*

2 Chapter 1

Poems, it expresses a woman's love for a valued part of her self. According to another feminist poet, this poem "finds unity where the culture propagates division: between a woman's sexuality and her spirituality, her creativity and her procreativity, herself and other women, her private and public self" (Ostriker 1986, 111).

The *uterus* is a woman's womb, which contains and nourishes a fetus during gestation. Most women also have two *ovaries*, which produce *ova* (eggs) and sex hormones. The normal nonpregnant human uterus weighs only approximately two ounces and is merely three inches long; the ovaries are even tinier, only one inch by one and a half inches. However, these sexual/reproductive organs carry great cultural and personal significance.

Most women do not consider the meanings of their uteruses and ovaries until they are faced with a crisis, as was Ann Sexton, whose poem is cited at the beginning of this chapter. In this book I explore the experiences of forty-four American women who have undergone hysterectomy (surgical removal of the uterus), with or without oophorectomy (surgical removal of the ovary), for benign conditions. Hysterectomy and oophorectomy offer women a unique opportunity to contemplate the meaning of their sexual reproductive organs in the context of female identity. One respondent described this crisis:

I never really thought about having a uterus and ovaries until they were gone. After surgery, I wondered what it meant to be without those body parts—I mean, I'm really confused, I don't really know—"Am I still a woman?" (Janet)

Her words highlight the potential challenge to gender identity that is the major theme of my research. I explore how—whether they perceived loss, stability, or enhancement—respondents dealt with possible contradictions in gender identity presented by absent sexual reproductive organs.

Definitions and Demographics of Hysterectomy

In popular (and even scholarly) usage, there is often confusion over precisely what body parts are removed during hysterectomy.¹

In fact, one or both of a woman’s ovaries may be left intact after hysterectomy unless she undergoes an additional surgery called *bilateral salpingo-oophorectomy* (bs-o), and her cervix may even remain following *subtotal hysterectomy*. Furthermore, the uterus may be removed through a variety of different types of hysterectomies. While abdominal surgery is currently the most common type, comprising 63 percent of all procedures, 23 percent are performed by the vaginal method; and vaginal laparoscopic hysterectomy now represents 10 percent of surgeries (Lepine et al. 1997). Table 1 (p. 4) indicates some medical definitions that help clarify the subject matter of this book.

A common belief that hysterectomy rates have decreased appreciably in the United States is not borne out by fact. Following criticisms regarding unnecessary hysterectomies, the annual rates of hysterectomies did decline moderately from 7.1 per 1,000 women in 1980 to 6.6 per 1,000 women in 1987. However, according to data from the Agency for Healthcare Quality, hysterectomy rates in the United States for noncancerous conditions changed little in the next decade—from 5.5 per 1,000 women in 1990 to 5.6 per 1,000 women in 1997 (Farquhar and Steiner 2002). This is despite the development of several new therapeutic techniques as alternatives to hysterectomy.²

Hysterectomy is currently the second most commonly performed surgical procedure in the United States.³ Each year approximately 600,000 American women undergo hysterectomies, a rate that is among the world’s highest—three to four times higher than in Australia, New Zealand, and almost all European countries (Farquhar and Steiner 2002). In fact, the uterus of at least one out of every three American women is eventually surgically removed, and approximately 75 percent of these surgeries are performed on women between the ages of 20 and 49, most of who are premenopausal.⁴ These statistics have remained constant over the last twenty years (Rock and Thompson 1997), though rates vary widely within the United States (nearly twice as high in the South as in the Northeast, for example) (Lepine et al. 1997).

Unlike mastectomies, most hysterectomies and oophorectomies are not performed to save lives: surgeries to treat cancer of

TABLE 1 Medical Definitions of Gynecological Surgery

<i>Name</i>	<i>Alternative Names and Abbreviations</i>	<i>Definition</i>
Subtotal hysterectomy	Partial hysterectomy Supracervical hysterectomy	Surgical removal of the <i>fundus</i> (body of the uterus)
Total abdominal hysterectomy	TAH	Abdominal surgical removal of the entire uterus, including both the <i>fundus</i> and the <i>cervix</i> (the neck of the uterus, which projects into the vagina and opens to release menstrual blood and to give birth)
Total vaginal hysterectomy	TVH	Surgical removal of the entire uterus, including both the <i>fundus</i> and the <i>cervix</i> , through the vagina
Laparoscopic assisted vaginal hysterectomy	LAVH TLH	Vaginal hysterectomy with visualization and resection of the uterine ligaments through a laparoscope that is inserted near the umbilicus, with the uterus removed through the vagina
Oophorectomy	Ovariectomy Ovarectomy Ovariectomy	Surgical removal of the ovary
Salpingo-oophorectomy		Surgical removal of the ovary and the connected <i>fallopian tube</i> (where the egg is fertilized and transported to the uterus)
Bilateral salpingo-oophorectomy	bs-o	Surgical removal of both fallopian tubes and both ovaries
Total hysterectomy– bilateral salpingo- oophorectomy	TAH-BSO TVH-BSO TLH-BSO	Removal of the entire uterus, both fallopian tubes, and both ovaries

the uterus, cervix, or ovaries account for only 10 percent of the total (Angier 1997; Franklin 1991). The most frequent reasons for hysterectomies and/or oophorectomies are for benign (though many times painful and annoying) conditions, including fibroid cysts, also known as leiomyomas (30 percent); endometriosis (20 percent); adenomyosis, sustained heavy bleeding (20 percent); pelvic inflammatory disease, genital prolapse (15 percent); and unexplained chronic pelvic pain (10 percent) (Brody 1993). Although the majority of hysterectomies and oophorectomies are considered “elective” because they are done for reasons that are not life threatening, it is unclear how much choice women actually have, since they are seldom privy to diverse and accurate information regarding these surgeries and alternatives (Lippert 1993). In fact, researchers have found that at least one-third of all American hysterectomies are probably “medically unnecessary” (Franklin 1991). Furthermore, according to the U.S. Centers for Disease Control and Prevention, healthy ovaries are also removed during a large proportion of hysterectomies (Angier 1997).

Michel Foucault’s work reinforces the extent to which “our bodies are trained, shaped, and impressed with the stamp of prevailing historical forms of selfhood, desire, masculinity, femininity” (Bordo 1993, 165–66). Long historical precedent associates women’s gender identities with their sexual reproductive organs; uteruses and ovaries have even been employed as a synecdoche for women in their entirety (Laqueur 1990).⁵ In fact, according to *New York Times* science reporter Natalie Angier, some medical sources claim that the uterus is “the only part of the body that is unique to women, the one organ that doesn’t have an anatomical equivalent in the male” (1999, 84).⁶ Hence, these body parts hold the potential to serve as “symbolic resources which facilitate interpretation” (cf. Olesen et al. 1990, 453) of cultural conceptions regarding female biology and feminine gender identity.⁷ The theory that uteruses and ovaries constitute the core of women’s gender identity implies that without these organs an individual may not be considered female. Accordingly, Wolf (1970, 165) depicts hysterectomy as “a surgical disruption to the self-concept of ‘fem-

inity' due to the central role of the uterus in the development of women's perspectives regarding body image, social role, and gender role. Women who have undergone hysterectomy may consequently see themselves as defeminised by having a hysterectomy."

Gender Identity

Although Goffman's claim that "gender, not religion, is the opiate of the masses" may be somewhat extreme, his contention that gender identity involves "the deepest sense of what one is" reflects an important social fact (1977, 315). While it is fashionable in some academic circles to insist that gender identity no longer matters, this is not the case in the real world. As Lynne Segal observes, "The idea that we are, or may soon become, post-gender exists alongside the continuing potency of the narrative of basic gender polarity" (2000, 120).

Many social theorists assert that gender identity is one of the most fundamental means by which individuals are recognized, both by others and by themselves. According to one scholar, "People may be described and categorized along many dimensions, but few seem to be as salient as gender. . . . [G]ender is an integral part of who we are, how we think about ourselves, and how others respond to us" (Katz 1979, 155). Another theorist concludes, "Being female or being male is a part of everyone's social identity from birth till death. Gender is at the core of what we 'really are'" (Stoll 1974, ix).

While gender is a primary identity for everyone, it may be particularly salient for women. For example, Deaux and Major (1990, 93) found that women are more likely to spontaneously describe themselves by gender than are men. Although many social theorists claim that gender is a crucial component of identity, there is disagreement as to what actually constitutes gender. Theories regarding gender generally begin with the assumption that biology, socialization, or social construction takes precedence. Either "anatomy is destiny," or social factors make biology moot. For clarity,

I will briefly summarize various theories of gender and then explain the approach that I find most reasonable.

Biological Essentialist Theories

The sociological concept of essentialism stems from philosophical arguments dating back to Aristotle that things, including people, have essences—necessary properties that make them what they are. The term *sex* has been related to the “natural” biological category of woman (or man), while *gender* has been connected to culturally produced processes. Biological essentialists generally believe that sex is inborn and that gender is the social manifestation of sex. According to this schema, there can only be two bipolar sexes and two bipolar genders. Sex can either be male or female; gender can only be masculine or feminine. According to most feminist analyses, biological essence is a conservative strategy often used as an excuse to sustain and fortify differences in male and female roles (e.g., de Beauvoir 1976; Friedan 1963; Millet 1970; Firestone 1970; Greer 1970). Nevertheless, several radical feminists have appropriated the concept of essence to argue that women’s essential nature is more prosocial than men’s (e.g. Sni-tow 1990; Ruddick 1989; Rich 1986a; Rossi 1977; Mitchell 1973). These theorists assert that patriarchal (male-dominated) society has alienated women from their essential nature, which should be strengthened, rather than minimized. Despite strong arguments from both sides of the political spectrum, a number of social scientists (e.g., Connell 1987; Deaux and Kite 1987; Epstein 1988; Lorber 1994) and biological scientists (e.g., Bleier 1984; Fausto-Sterling 1985; 1987; 1993; Hubbard, Henifen, and Fried 1977) have critiqued the biological essentialist model of gender by describing the circular process by which purportedly objective and natural understandings of sex are actually shaped by social influences.

Cultural Essentialist Theories

Sex role or socialization theories of gender view society and nature as additive. They assert that the “natural” dichotomy between genders is clarified through cultural elaboration. While the bio-

logical essentialist position emphasizes that gender behavior is inherently tied to sex, sex role or socialization theory maintains that gender is learned through an individual's developing understanding of what characteristics and behaviors are considered culturally acceptable for individuals who are born either male or female (Howard and Hollander 1997).

Although socialization theories connect social structure to personality formation, they generally rely on stereotyped interpersonal expectations that do not explain the association between personal agency and social structure (Connell 1987). Like biological essentialist theory, sex role or socialization theories still define gender in terms of dichotomous difference. Males or females are expected to enact only one of two gendered roles, the "masculine" or the "feminine." Accordingly, social gender is no more flexible than biological sex, and socialization or sex role theory may be interpreted as a form of cultural essentialism.

Social Constructionist Theories

In general, the social constructionist position on gender, founded on symbolic interaction, maintains that gender is created through interpersonal interpretation of action. The insight that gender identity is not just something a person is, but is produced through performance, has origins in the work of Erving Goffman (1977), who focuses on "gender displays" as highly conventionalized behaviors that are situational rather than ongoing. Social constructionists expand this concept to assert that gender is an emergent feature of social situations rather than a property of individuals (West and Zimmerman 1987).

Ethnomethodology is a form of social construction that is particularly useful for examining social phenomena by analyzing how "irreducible facts" accepted by members of a shared culture are actually beliefs produced through social interaction. Harold Garfinkel (1967), the founder of ethnomethodology, used a case study of "Agnes," a transsexual, to demonstrate that gender is accomplished through everyday behavior. Agnes was able to convince people that she was a woman by learning to enact "womanly"

mannerisms, dress, and behavior. Garfinkel maintained that Agnes’s strategies of self-presentation are entirely comparable to the strategies employed by “normal” females, which are so taken for granted that they are invisible.

Building on the ethnomethodological approach, Suzanne Kessler and Wendy McKenna claim that a “gender attribution” (the decision whether an individual is either male or female) is made every time we see a new person. Furthermore, they argue, “The ‘decision’ that we make as to whether that person is a man or a woman is not stated in terms of probabilities.” People are considered to be “either one or the other, zero or 100 percent” (1978, 2). Despite the fact that there is considerable individual variation in characteristics, gender is commonly attributed as bipolar rather than as a continuum of possibilities. “It is only by questioning dichotomous criteria for gender attributions,” Kessler and McKenna claim, “that the dichotomous nature of gender, itself, becomes problematic” (12). According to these sociologists, gender identity “refers to an individual’s own feeling of whether she or he is a woman or a man, or a girl or a boy. In essence gender identity is self-attribution of gender” (8). Kessler and McKenna propose that people do not always follow the same rules when attributing gender to self and to others. However, they assert that it is difficult for an individual to maintain a self-image without a clear gender identity.

Kessler and McKenna are among the growing number of social theorists who argue that not only gender but also the bipolar categories of biological sex are socially constructed (see also Scott 1988). According to this theoretical position, “society not only shapes personality and behavior, it also shapes the ways in which the body appears. But if the body is itself always seen through social interpretation, then sex is not something that is separate from gender, but is, rather, that which is subsumable under it” (Nicholson 1994, 79).

Gender is presumably assigned to people based on their genitals, internal organs, or chromosomes. Nonetheless, gender attributions in everyday life are made, not by undressing people or by

administering physical exams or laboratory tests, but through observing cultural factors of behavior, dress, mannerisms, and so forth. Therefore, biological theories of gender actually rely on the social process of gender attribution. Social constructionists consider gender to be an emergent feature of social situations rather than a property of individuals. As empirical proof, Kessler and McKenna (1978) discuss examples of individuals who illuminate the social rules regarding gender through transgression of these rules. These include transsexuals, intersexuals, and other individuals with unusual chromosomal and hormonal characteristics. My intention in undertaking the current study was to explore the phenomenon of gender identity by studying individuals who have undergone surgical removal of their uterus (hysterectomy) and/or their ovaries (oophorectomy), a far more ordinary experience than the examples employed by Kessler and McKenna.

Based on their analysis that sex is subordinate to gender, Kessler and McKenna (1978) employ the term *gender* even when discussing biological differences. Meredith Kimball also recommends using *gender* as a general term to emphasize that all differences, even if based in biology, are socially constructed: "The use of gender is to remind myself and the reader that any particular difference or similarity is the result of complex and sometimes contradictory social processes that involve individuals, social institutions, and cultural beliefs" (1995, 18–19; see also Deaux 1993; Unger and Crawford 1993). Since I consider this an appropriate practice, I refer to *gender identity* rather than *sex identity* throughout this book.

Performance Theories

The performance theory of gender developed by philosopher Judith Butler is somewhat compatible with the social constructionist perspective in sociology. Butler (1993) denies that the formulation of gender is the cultural interpretation of sex; rather, she believes that sex is produced and established through cultural discourses. In addition, she emphasizes that the subject who becomes a woman is not necessarily biologically female. According to her theory, gender does not follow naturally from sex; "natu-

ralization” is a difficult and continuing process and can be confirmed only through repeated performance. For Butler, gender is never a stable identity but is always a process of becoming, and sex is not a given but an “artificial unity” imposed on “an otherwise discontinuous set of attributes” (1993, 114). As Jennifer Harding points out, “The notion of performance fits more closely with popular cultural perceptions that femininity is an elusive ideal which must be constantly sought but never attained, and with some feminist descriptions of femininity as an identity in process, never complete” (1998, 3).

Toward a Synthesis of Theories about Gender

As I delineate in later chapters, the women that I interviewed struggled with their own lay versions of biological essentialist, sex role, social construction, and performance theories. While I find social constructionist theory the most useful approach to studying gender identity, this perspective does not entirely describe the experience of living in a biological body. Robert Connell (1987) is one of several social theorists who warn against emphasizing the social aspects of gender to the point of minimizing the importance of the material body. It is crucial to bear in mind that an individual develops her sense of identity from perceptions received through her body and expresses her identity through her body. Yet as Elizabeth Spelman (1988) aptly points out, feminist sociology has tended to be particularly “somatophobic” because women’s bodies have been the basis for biological determinism. As I will demonstrate throughout this book, respondents’ experiences indicate that the biological essentialist position, which associates sexual reproductive organs with the essence of being a woman, is highly problematic. However, this does not mean that ovaries and uteruses have nothing to do with gender identity, as other respondents discuss. The women I interviewed continuously cross back and forth between the boundaries of woman as sex (biology) and as gender (social and cultural prescriptions).

Other social theorists articulate a position that synthesizes seemingly disparate perspectives regarding gender. “In and of itself, es-

sentialism is neither good nor bad, progressive nor reactionary, beneficial nor dangerous,” Diana Fuss (1989, xi) proposes. She further argues that there is no clear distinction between essentialist and social constructionist discourses. According to her, constructionism is actually only “a more sophisticated form of essentialism” (xii). She maintains that, while constructionists challenge the historicity of essentialism, they also “often work with uncomplicated or essentializing notions of history. While a constructionist might recognize that *man* and *woman* are produced across a spectrum of discourses, the categories *man* and *woman* still remain constant” (3). According to this rationale, social constructionist theories must incorporate essentialism.

Sociologists Simon Williams and Gillian Bendelow examine the claims of essentialism and social construction and propose a “third stage of conceptual development” (1998, 3). They suggest that the term *embodiment* provides the means for partially transcending the “nature vs. culture” debate. Williams and Bendelow argue the need for an “embodied sociology” that would shift from theorizing *about* bodies in a disembodied manner to perspectives of theorizing *from* lived bodies. They therefore call for a move “towards a more integrated social theory of embodiment—one that links (lived) *experience* to (cultural) *representation*” (1998, 3). This is compatible with Adrienne Rich’s suggestion that feminists remind ourselves that the body is not only an abstract construct but also a material fact of life (1986b, 215). Since I agree with these theorists, this book emphasizes personal embodied experience over universal theories of bodies.

Helen Marshall advocates that a phenomenological approach is fundamental to theorizing the body and expresses concern that “so much attention is being paid to nomenclature and theory, and so little to the lived experiences and data” (1996, 255). In order to understand the lived experiences of respondents, I have recognized that respondents inhabit real bodies, not just cultural representations of bodies. The pain that they feel, both physical and emotional, is authentic. As a sociologist, I view the social envi-

ronment as crucial; and accordingly, paying attention to the biological body does not mean that I endorse biological reductionism. I support Susan Bordo's contention that the female body is “*both construction and resource*” (1993, 36). My goal is to understand the complicated interaction between body and society in order to interpret respondents' experiences. To rely exclusively on one particular theory of gender would “turn what is valuable as a partial vision into a flawed whole” (Kimball 1995, 1). The perspective from which I have analyzed and interpreted respondents' interviews is thus that *the body is not totally constructed by social discourse or socialization processes, nor does it exist completely independently of these.*

To paraphrase Steven Epstein (1990, 286), “Neither strict constructionism nor strict essentialism are capable of [fully] explaining what it means to be [a woman].” *Woman* is at the same time an “empty” and “overflowing” category (Lorber 1994; Scott 1988); it can represent biology, socialization, role performance, or discourse. In this book, I apply the term *woman* to both sex and gender. Since respondents used the term in each of these ways, I reflect their multiple meanings of *woman* in my analysis. I hope to further the theoretical move toward reconciling the materiality and social construction of women's bodies.

Biographical Disruption of Gender Identity

My research and analysis employs the *experience of illness perspective* within medical sociology, which focuses on subjective understanding of what it is like to have a medical condition (see Conrad 1987; Fitzpatrick et al. 1984; Schneider and Conrad 1983). The chronic conditions of having undergone hysterectomy and oophorectomy fit Conrad's definition of “lived-with illnesses” because people must adapt and learn to live with them, but they are not (usually) life-threatening. This is similar to Greil's (1991a; 1991b) contention that the condition of infertility can be seen as comparable to chronic illness.

Medical events often generate *biographical disruptions* or *turning points*; the individual's concept of who she or he is will never be the same as before.⁸ Bryan Turner maintains that a sociology of the body allows medical sociologists to appreciate "the intimate and necessary relationship between my sense of myself, my awareness of the integrity of my body and experience of illness as not simply an attack on my instrumental body (*körper*) but as a radical intrusion into my embodied selfhood" (1992, 167). Accordingly, "to change our embodiment is to change our identity" (256). Turner's work is foundational for my specific project of examining the effects of gynecological surgery on gender identity.

Michael Bury (1982, 169) conceptualizes chronic illness as "a major kind of disruptive experience, or, using Anthony Giddens (1979) term, 'critical situation.'" Bury connects three aspects of disruption to chronic illness: disruption of taken-for-granted assumptions and behaviors; more profound disruptions in explanatory systems that cause an individual to rethink her or his own biography and self-concept; and finally, the necessary mobilization of resources to face the crisis in identity. A similar concept is found in Juliet Corbin and Anselm Strauss's concept of *turning points* in chronic illness (1985, 1987). Turning points are seen as critical incidents that force individuals to recognize that their lives have changed in crucial ways and that they will have to reevaluate and revise their former assumed identities (Strauss 1959). Turning points may be met with a diversity of emotional reactions and coping strategies.

Kathy Charmaz has done some of the most interesting work regarding the impact of chronic conditions on identity. In several articles (1983; 1987; 1990; 1994; 1999a; 1999b) and her book (1991), she employs the symbolic interactionist perspective to discover the ways in which physical diversity can result in a "loss of self." Virginia Olesen and her co-authors observe that even minor bodily disturbances such as a rash can cause sufferers to alter their views of themselves. They argue that people who suffer more severe bodily changes through surgery (i.e., ostomates) do not

merely see changed images of their bodies; they perceive themselves as “transformed beings whose physical and social capacities had been substantially altered” (Olesen et al. 1990, 452). All of this sociological research supports my specific project of examining the effects of hysterectomy and/or oophorectomy on gender identity.

Brief Historical Background of Hysterectomy and Oophorectomy

Hysterectomy and oophorectomy constitute surgeries that have long histories. Throughout differing time periods, the significance of wombs and ovaries and the effect of these gynecological surgeries on the perception of an individual’s *womanhood* have been interpreted very differently.

Prior to empirical studies about the effects of oophorectomy and hysterectomy, a variety of cultural theories proposed the importance of female reproductive organs. For example, the ancient Egyptians and Greeks attributed women’s supposed emotional instability to a “wandering womb.” In fact, the root of the term *hysteria* derives from the Greek word *hyster*, meaning womb. Hippocrates theorized that the human uterus had numerous chambers and was lined with “tentacles” or “suckers,” an erroneous belief that persisted until the Renaissance, due to prohibitions regarding dissection of the human body (Angier 1999). Surgery to remove the uterus was apparently accomplished in ancient times, with the first recorded hysterectomy performed by the Greek physician Arhigenes in A.D. 100. Vaginal hysterectomy was the traditional way to remove the uterus in antiquity.

Notions that the womb dominated the female body in ways that could cause a woman to go mad continued well into the nineteenth century. As the concept of the body as an organism gave way to a view of the body as a machine during the nineteenth century, female bodies were found particularly defective and in need of repair. The growing profession of gynecology appropriated

primary responsibility for the female body (Barker-Benfield 1976). Ovariectomies were first performed in the early nineteenth century for the purpose of removing huge ovarian tumors. Later, surgeries to excise ovaries were no longer limited to purely medical rationales. The belief that the reproductive organs completely controlled women's bodies and minds between puberty and menopause provoked their removal for a wide variety of reasons.⁹ Victorian physicians insisted that the "instability of their reproductive systems interfered with [women's] sexual, emotional, and rational control" (Showalter 1987, 55). Removing healthy female organs was seen as necessary in order to cure the "so-called failures of femininity" (Laqueur 1990, 176), which included "ovario-mania," "hystero-epilepsy," nymphomania, masturbation, suicidal tendencies, dysmenorrhea, overeating, and many other physical and psychological symptoms. After the advent of anesthesia in the nineteenth century, abdominal hysterectomy surpassed vaginal hysterectomy as the predominant method of removing the uterus.¹⁰ As hysterectomy became a medically safer operation, it replaced *ovariotomy* as a "cure" for a variety of women's presumed physiological and psychological problems, most notably hysteria and melancholia (an early concept of depression). Physicians continued to perform this surgery despite the fact that out of 400 hysterectomies from 1881 to 1885, there was a 50 percent death rate (Dally 1991, 220).

Finally, at the turn of the twentieth century, members of the medical community began to denounce the practice of widespread *normal ovariectomy*, the surgical removal of the ovaries for other than physical problems (Dally 1991). Eventually, normal ovariectomy was banned in many places, and surgeons who performed it were referred to as "belly-rippers." Some historical researchers assert that the medical profession condemned gynecological surgery performed for psychological and behavioral rationales primarily because it failed the objective of inducing women to conform to their expected gender roles (see Barker-Benfield 1976). The current medical assumption is that hysterectomies and

oophorectomies are performed solely for physical problems, although this is not always the case (Bernstein et al. 1997).

Previous Scholarly Research

Although feminist sociologists have conducted extensive research on the lived experiences of “natural” menopause (e.g., Bell 1987; Kaufert 1982; Rogers 1997), they have not sufficiently explored the experiences of women who reach this stage through surgery. With the exception of my own work on the subject, previous sociological discussions regarding hysterectomy have focused almost entirely on this surgery as an example of medical misogyny and social control (e.g., Fisher 1986, Scully 1994).¹¹ While this is an important aspect, the removal of sexual reproductive organs can also present an opportunity to provide insight into the relationship between cultural and lived experiences of the gendered body. Given the frequency with which women undergo hysterectomy and the removal of their ovaries (oophorectomy), it is surprising that sociologists have not previously conducted more sophisticated analyses of the impact these surgeries may have on the social construction of gender identity.

Medical doctors, nurses, and psychologists have conducted the overwhelming majority of studies on psychosocial outcomes of oophorectomy and hysterectomy, both prospective and retrospective. Major difficulties that arise in comparing previous studies regarding women’s experiences with hysterectomy include dissimilar methodologies: large variations in measures of emotional symptoms, length of follow-up, and wording of survey questions (Bernstein et al. 1997). Findings from these studies vary widely, with estimates of the proportion of women suffering from post-operative psychological problems ranging from 4 percent to 66 percent (Bernstein et al. 1997). This impedes definitive conclusions.

Much of the medical and psychological research does indicate that women may suffer negative emotional outcomes as a result of hysterectomy, particularly related to feelings of the loss of fem-

inity.¹² For example, according to Polivy, “a threat to [sexual/reproductive organs] can easily constitute a threat to a woman’s whole self-concept” (1974, 417). Correspondingly, Kaltreider, Wallace, and Horowitz (1979) claim that depression and other negative psychological consequences following hysterectomy are prompted by a major negative alteration in an individual’s internal image of herself as a woman. Webb and Wilson-Barnett found: “A review of over sixty articles in medical journals suggests that women recovering from hysterectomy may find their image of themselves radically changed even though there is no visible alteration in the body. For some women, having a hysterectomy may pose a profound threat to their self-concept as a feminine person, an attractive sexual being for whom childbearing has been a major and highly valued social role” (1983, 97). However, in their own study, these researchers did not find that self-concept was damaged. A primary objective of this book is to investigate whether respondents do experience this loss to gender identity, and if so, specifically how it is manifested.

While many previous studies show that women experience negative identity consequences, other medical and psychological research finds that women do *not* suffer losses to their gender identities as a result of gynecological surgery. Several studies assert that subjects’ feelings regarding their gender identities are not changed in any way by hysterectomy.¹³ Even more surprising in light of other studies showing negative emotional outcomes, some medical and psychological research claims that women experience marked *improvement* in mood after hysterectomy.¹⁴ I also examine this proposition, particularly since these studies do not fully explore the reasons behind reported neutral or positive emotional effects.

Some medical and psychological research attempts to establish that women who undergo hysterectomy have a history of previous psychosocial problems prior to surgery,¹⁵ but these studies do not adequately explain the reasons for this connection. These researchers may be practicing an unfounded “blaming the victim” that implies that women’s depression may actually cause them to

seek hysterectomies. The inherent assumption in these studies is that depression is the independent variable. However, as described in the following chapters, my research demonstrates that many women endure extended periods of heavy bleeding and intense pain prior to finally undergoing hysterectomies. It is more likely that this physical suffering is the independent variable that causes psychological symptoms prior to surgery and is also the medical reason for hysterectomy.

Earlier studies on hysterectomy include several major weaknesses. First, the most prominent research (Cosper, Fuller, and Robinson 1978; Drelich and Bieber 1958; Hampton and Tarnasky 1974; Kaltreider, Wallace, and Horowitz 1979; Patterson and Craig 1963; Polivy 1974; B. Richards 1978; D. Richards 1974; Webb and Wilson-Barnett 1983) was conducted many years ago, whereas both scholarly and lay conceptions of gender have changed considerably since then. Second, previous researchers generally neglected to separate out the effects of hysterectomy (removal of the uterus) for women who retained their ovaries and those who did not. Another important problem with most scholarly work is the researchers' assumptions that women's reactions to gynecological surgery are uniform, despite differing social factors such as age and menopausal status at the time of surgery, desire for (more) children, significant emotional and sexual relationships, and the personal salience of gender identity. Finally, most previous studies did not make use of intensive interviewing in order to focus on the lived experiences of women who have undergone these surgeries (Ryan 1997).

Self-Help Discourse

A proliferation of self-help literature regarding women's health issues has been stimulated by the women's health movement (Zimmerman 1987). As Allwood (1996) points out, “The self-help genre is one that has been mainly directed towards women, and provides a site to examine contested notions of expertise and responsibility in a specific area” (qtd. in Lyons and Griffin 2000, 470). Self-help books on hysterectomy and oophorectomy generally in-

clude detailed descriptions of the experiences of women who have undergone these surgeries.

I have reviewed seventeen self-help books regarding hysterectomy.¹⁶ These books are sometimes intended to offer advice to women who have already had hysterectomies but are most often written for an audience facing the possibility of future surgery.¹⁷ The titles of many of these books—for example, *No More Hysterectomies* (Hufnagel 1988); *Male Practice: How Doctors Manipulate Women* (Mendelsohn 1981); *You Don't Need a Hysterectomy* (Strausz 1993); *The Castrated Woman: What Your Doctor Won't Tell You About Hysterectomy* (Stokes 1986); *The Ultimate Rape: What Every Woman Should Know About Hysterectomies and Ovarian Removal* (Plourde 1998)—generally reflect the concept that gynecological surgery is to be avoided at all costs. A common opening line from one of these self-help books reads: “In this book I will give you ammunition to defend yourself against hysterectomy” (West 1994, 13).

Self-help books include narratives from women who have undergone or were spared from undergoing hysterectomy or oophorectomy. These narratives are often framed as cautionary tales, including “winners” (those who kept their sexual reproductive organs, and in several examples even got pregnant) and “losers” (those who lost their uteruses and/or ovaries). In most triumphant accounts, a woman combats a member of the medical establishment in order to save herself. She becomes a “winner” either by resisting surgery herself or being saved by, or with the help of, another individual, usually a “white knight” husband or enlightened physician. The discussion of gynecological surgery in terms of informed decision making is especially striking. These books offer a form of resistance and thus provide an alternative discourse to medical discourse on gynecological surgery.

The “Hyster Sisters Recovery Web site” was launched in 1998 with the stated purpose of serving women who had either undergone or were anticipating hysterectomy. In 2001, a book based on the Web site was published; it was called *Through the Land of Hyster: The Hyster Sister Guide* (Kelley 2001). Similar to other self-help literature regarding hysterectomy, this Web site and book portray