

# ROLE OF SOCIAL RESOURCE VARIABLES UPON LIFE SATISFACTION IN BLACK CLIMACTERIC HYSTERECTOMIZED WOMEN

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Hysterectomy, the surgical removal of the uterus, is the most commonly performed major surgery in the United States. In 1975, the incidence of hysterectomies peaked at 808,000. Although in 1980 there was a slight decrease, 5.6 per 1,000, America still has the highest rate of hysterectomies in the world (Finck, 1979; Krueger, Hassell, Goggins, Ishimatsu, Pablico, & Tuttle, 1979; U.S. Superintendent of Documents, 1983). Over the years, perhaps no other surgical procedure has prompted more concern among the medical profession, government agencies, third-party payers, feminist groups, and the laity about its indications and possible overuse (Doyle, 1953; Larned, 1974; Miller, 1946; Parrott, 1972). In response to this widespread concern, a Policy Statement — "The Determination of the Necessity of Gynecological Surgery" was issued by the Executive Board of the American College of Obstetricians and Gynecologists (1977). Equally alarming over the years are reports that removal of non-pathological uteri constitutes 32-39% of the total number of hysterectomies performed each year (Doyle, 1953; Zussman, Zussman, Sunley, & Bjornson, 1981). "It is fairly clear that socio-economic status may be a selective factor in determining who is to be hysterectomized" (Patterson, Craig, Dinitz, Lefton, & Pasamanick, 1960). It was documented in the mid-fifties that the percentage of hysterectomies performed on medically uninsured women is double that of insured (Anderson & Feldman, 1956), leading Parlee (1978) to conclude that "there is some suggestion that the figure may be related to the race and social class of the woman, as to whether or not she had medical insurance..." (p. 36).

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Although the majority of the reported hysterectomy studies on white women are retrospective in design, and the methodology used is subject to criticism, there are a number of these empirical studies reporting that post-hysterectomy adjustment is often associated with elevated level of depression (Barker, 1968; Drellich & Bieber, 1958; Richards, 1974, depressed levels of feminine self-concept (Deutsch, 1945; Drellich & Bieber, 1958; Williams, 1973), psychosocial stress (Melody, 1962; Raphael, 1976) and psychiatric morbidity generally (Richards, 1974). Therefore, scientific investigation of this possible health risk problem is one of considerable urgency for a large number of women.

Although voluminous studies as well as clinical articles have reported on white hysterectomized women, and on their post-operative course of adjustment, a review of the literature indicates little or no evidence of scientific information on black hysterectomized women as a sub-group within the major culture of American or Canadian society. The study of closest relevance is that of Williams (1973) who investigated two ethnic groups, Anglo- and Mexican-American, and documented the effect ethnicity and culture had upon their pre-hospitalized and post-hysterectomized adjustments to the surgical removal of the uterus. She found marked differences existed between responses of the two groups that reflected contrasting levels of feminine self-concept, self-esteem, and coping ability. She concluded that these differences were primarily the result of ethnicity and culture. The theoretical and practical clinical significance of the conditioning effects of social support on a wide range of stress events justifies evaluation of its validity on this sample of black climacteric hysterectomized women.

### Purpose

The purpose of this study was to investigate the role of the social resource variables upon life satisfaction of black climacteric hysterectomized women. These variables were defined in terms of five components: (1) husband or sexual partner; (2) children as source of support; (3) female relatives as confidants; (4) female friends as confidants, and (5) members of voluntary organizations.

Social support was defined as social and emotional support with the affirmation that one is loved and cared for. Confidants were defined as close female relatives and friends with whom personal and private concerns were shared. Life satisfaction was defined as the maintenance of one's self-esteem, one's coping abilities and one's sense of mastery over life's circumstances.

## Review of Literature

Empirical studies have linked social support with positive outcomes of stressful life events in a variety of population samples, and have evaluated its influence as an effective buffer against negative personal experiences. Cobb (1976), defining social support as information leading one to believe he or she is loved, cared for, valued, and esteemed, found that quality involvement with others reduced the effect of such stresses as job loss, bereavement, aging and retirement, and recovery from traumatogenic illness. Nuckolls, Cassel, and Kaplan (1972) investigated the socio-emotional support for wives in their 32nd week of pregnancy from husbands, relatives, friends, and community and found that high stress was unrelated to the percentage of complications among women with high quality social support. Among women with high stress and low quality support, however, the percentage of pregnancy complications was significantly elevated.

Likewise, friendship and kinship, as social support, have been described as effective buffers against a variety of stress events in the lives of women in midlife crisis. Robertson (1978) investigated the value of friendships and kinships and reported that friendships were often value above kinships. In addition, Myers, Linderthal, and Pepper (1975) reporting on the concept of social support, stated that "people who have ready and meaningful access to others, feel integrated into the system, and are satisfied with their roles, seem better able to cope with the impact of life events" (p. 426). Even the availability of someone to talk to on superficial issues has been documented as having salutary effects upon levels of psychological adjustments and on recovery from major illnesses and other life events (Williams, Ware, & Donald, 1981).

### **Husband or Sexual Partner**

Although having a hysterectomy has been perceived as an emotional blow by almost every woman who has had one, some were able to bring into play adequate coping mechanisms to establish and maintain healthy adjustments in response to having a hysterectomy (Turpin & Heath, 1979). However, several researchers and clinicians have reported statements of hysterectomized women that indicated a wide range of feelings toward the effects of hysterectomy on their feminine self-concept. "If you don't have a womb, you are not a woman" (Wolf, 1970, p. 167); "I feel useless and not a whole woman... I am only a shell of a woman" (Melody, 1962, pp. 412-413); and "you are not a proper woman, if you can't have any more children" (Raphael, 1976, p. 430).

Williams (1973) reported feelings, expressed by Mexican-American hysterectomized women, of overt concern and fear about infidelity

and about losing their husbands to other women following hysterectomy. "I was afraid my husband would leave me... I was afraid he would get another woman if I wasn't any good" (Williams, 1973, p. 382). One woman reported that she had suffered for years from postponing the hysterectomy, which had been medically recommended, for fear of losing her husband. Another woman who reluctantly had the operation did not tell her husband the truth, that the uterus was removed, for fear that he would no longer consider her a sexually attractive partner (Williams, 1973). Although the extent of such insecurity in the women's feminine self-concept in their marital relationship may have been culturally determined, these expressions, nevertheless, indicate the perceived importance of the uterus in maintaining their feminine self-concept in an intimate relationship, and of its function as the primary link between the marital bond and fidelity. In the mid-fifties, Drellich, Bieber, and Sutherland reported similar expression of women from other cultures. One woman told her husband after having a hysterectomy that only one ovary was removed for fear he would feel she was no longer useful for work or sex.

Nor are such personal feelings and fears unrealistic. Some husbands and sexual partners have asserted that, for them, their partner's feminine attractiveness had altered following hysterectomy. Some women have experienced unhelpful interactions with their husbands or sexual partners that they consider derogatory to their perceptions of themselves as women and sexual partners, and they have had to grapple with hurtful and rejected feelings. In extreme instances, desertion, taunting, and physical and emotional divorce within the intimate relationship have been documented as preceding depressive reactions in hysterectomized women (Barker, 1968; Drellich, Bieber, & Sutherland, 1956; Melody, 1962; Raphael, 1976).

Melody (1962), who stressed the importance of quality relationships and social interactions, which he believed invariably determined the post-operative course, said: "Intimate human relations and interactions are so essential to health that one's sanity and potential for self-fulfillment are jeopardized for the most part by the perceived thread of disapproval, rejection, devaluation, or loss of security" (p. 410).

It is interesting to note that Brown and Harris (1978), who investigated the relationship between depression and intimate relationships, found "that women with confiding intimate relationships had only one-fourth of the incidence of depression of those with high stress but little support" (p. 363). Investigators have found that successful post-hysterectomy adjustment was dependent upon the quality of emotional support, and on an intimate relationship with husband or sexual partner, in providing acceptance and approval of the hysterectomized woman (Melody, 1962; Raphael, 1976, Williams, 1973).



### *Children as Source of Support*

Investigators have found that some women have reported that it was not only the quality of intimate relationships, but also the quality relationships with their children that were sources of special support from which they were able to sustain themselves during periods of personal stress or crisis. However, the mother's self-image often comes up against the realities of her children's aloofness, rejection, indifference, and, sometimes, disappointments, all of which she must integrate into her personal experience (Benedek, 1950; Deutsch, 1945; McAdoo, 1980; Rodgers, 1980).

### *Female Relatives and Friends as Confidants*

Raphael (1976) believed that the extent to which most women withstand or cope with a hysterectomy also depends, to a considerable degree, on social network components which often include mothers, close female relatives, and friends. Equally important are the caring and empathic understanding qualities expressed by their doctors. She approached her investigations concerning the quality of life in post-hysterectomized women by conceptualizing hysterectomy as a psycho-social crisis. Some women find themselves, at the time of the hysterectomy, without a supportive environment, a husband or sexual partner, but fortunately these women often are able to rely on other women for information and reassurance. Close female relatives and friends often fill the role of confidant with whom the hysterectomized woman shares perceptions and fantasies about the operation, particularly if these women have had similar experiences (Drellich & Bieber, 1958; Melody, 1962; Raphael, 1976).

### *Members of Voluntary Social Organizations*

Several investigators have explored the relationship between life adjustment and social interaction through the medium of voluntary social organizations, and have found that the two are significantly correlated (Palmore & Luikart, 1972; Tobin & Neugarten, 1961). Church groups, self-help groups, and mutual aid groups, which provide support for social, emotional, and spiritual concerns, have been found to be effective because people affect each other through multiple linkage and chain reactions as they share their fears, their knowledge, and their ways of coping (Maguire, 1983). Other researchers have found statistical support for the relationship between social interactions and quality of adjustment and mid-life, and have systematically linked social support to the quality of one's life. Even where the involvement may have been superficial, the availability of such formal or informal social involvements has played a significant role in

physical and psychological adjustment and recovery.

### Conceptual Framework

Anthropologists and sociologists were the first to document empirically the effects of social support associated with the primary reference group. More recently psychologists, sociologists, and epidemiologists have considered empirically and theoretically the therapeutic effectiveness of social support systems.

Supportive social relationships have been shown to be effective buffers against the negative consequences of a wide variety of social stressors: puerperal depression (Paykel, Emms, Fletcher, & Rassaby, 1980); marital separation (Weiss, 1975); mastectomy (Bloom, 1979); and divorce (Hetherington, Cox, & Cox, 1978). In addition, social and emotional support have been documented as being effective in the remediation of physical symptoms and illness: in reducing migraine headache, asthma, and essential hypertension (Berle, Pinsky, Wolf, & Wolff, 1952), in coping with mastectomy (Bloom, 1979), in reducing anxiety in relatives of loved ones with life-threatening illness (Bunn & Clarke, 1979), in recovering from strokes (Robertson & Suinn, 1968), in rehabilitation outcome of orthopedically disabled patients (Litman, 1966), and in producing favorable outcomes of myocardial infarction (Finlayson, 1976). Social support from social networks, as Cobb (1976) has noted, "...has beneficial effects on a wide variety of health variables throughout the life course from conception to just before death" (p. 113).

A clue as to why social networks indicate such positive health outcomes is given in Cobb's (1976) identification of three components of social support: (1) emotional support is "information that one is cared for and loved," (2) esteem support is "information that one is valued and esteemed," and (3) network support is "information that one belongs to a network of mutual obligations" (p. 119). People usually look to others, particularly members of their families for recognition of their worth and value, especially where it involves serious illness or disfigurement (Moos & Tsu, 1977). This is crucial to one's self-image and the feelings of self-esteem that enable the individual to build a new identity and cope with readjustment.

For this study, the investigator used social networks involving husband or sexual partner, children, female friends, relatives who are confidants, and members of voluntary social organizations to explain *the relation between post-hysterectomy adjustment and the quality of support that black hysterectomized women received.*

Based upon the preceding review, the following hypotheses are offered:

1. Black hysterectomized women who have more extensive and better quality relationships with their husbands or sexual partners will report higher levels of life satisfaction than those with less extensive and poorer quality relationships.

2. Black hysterectomized women with more extensive and better quality relationships with their children will report higher levels of life satisfaction than those with less extensive and poorer quality relationships.

3. Black hysterectomized women with more extensive and better quality relationships with their female relatives will report higher levels of life satisfaction than those with less extensive and poorer quality relationships with relatives.

4. Black hysterectomized women with more extensive and better quality relationships with female friends will report higher levels of life satisfaction than those with less extensive and poorer quality relationships with friends.

5. Black hysterectomized women with more extensive and better quality involvement with members of voluntary social organizations will report higher levels of life satisfaction than those with less extensive and poorer quality involvement with social organizations.

## Methodology

### *Sample*

A final voluntary convenience sample consisted of 89 black hysterectomized women between the ages of 40 and 60, who were born and raised in the United States, who reported no psychiatric hospitalization, and who signed a consent form. This was obtained from a larger survey sample of 209 black climacteric women. The setting from which they were obtained included one ambulatory care clinic in a health center, one community health clinic, one black sorority organization, the private practice of two black gynecologists, several educational institutions and community organizations, and many black churches, all located in an urban area. The mean age of this sample was 50.8 years; 79.9% were Protestant; 42.8% were married, 21.3% divorced, 6.7% never married and the remaining 29.2% remarried, separated, or widowed. Of this sample of 89 women, 69.7% reported that they were in good to excellent health, and 18.0%, 76.4%, and 5.6% reported they were hysterectomized before, during, and after the cessation of menstruation, respectively. Over 53% of the sample reported that they had undergone surgical menopause before age 41. Educationally, 10% reported completion of the 9th grade, 36% reported that they had graduated from high school, and

53% reported formal training beyond high school.

### *Procedure*

Individual respondents to the questionnaires were asked to participate voluntarily. A letter of introduction to the investigator, with information about the need for the study and the importance of her participation, was sent to each participant. Two consent forms were enclosed — one for the respondent to keep, the other to be signed and returned — along with assurances that all information would be kept in strict confidence.

Coded sets of questionnaires were mailed out to each participant. Also enclosed were two self-addressed stamped envelopes — one for the return of the signed consent form and the other for the return of the completed questionnaires. Signatures were separated from protocols, thus providing a further degree of confidentiality.

### *Instruments*

1. Neugarten, Havinghurst, and Tobin's (1961) measure of life satisfaction, Life Satisfaction Index (LSIA), has been accepted as reliable and valid, although primarily for white samples. This measure is theoretically and empirically structured around five components:

a. Zest versus apathy: The respondent's enthusiasm of response and degree of ego involvement in any of the various activities that involves the respondent and other people.

b. Resolution and fortitude: The extent to which the respondent regards his life as meaningful and accepts resolutely that which his life has been.

c. Congruence between desired and achieved goals: The extent to which respondent feels he has achieved certain goals in life, whatever those goals might be.

d. Self-concept: The respondent's concept of self-physical as well as psychological and social attributes.

e. Mood tone: The extent to which the respondent expresses happy, optimistic attitudes, depression, feeling blue and lonely, or feelings of bitterness (Neugarten et al., 1961, pp. 137-139).

The full set of 20 items was used as recommended by Neugarten et al. For this sample of black women, the items were scored giving 2 points for an affirmative response, 1 point for each uncertain response, and 0 for each non-affirmative response. The dependent variable, life satisfaction, was measured by this 20 item LSIA scale.



2. The second instrument, developed, piloted, and refined on a sample of 120 black climacteric women by the author, has acceptable reliability and distributional characteristics (Jackson, 1982). The items were structure around those areas identified in the literature review as important in understanding climacteric and post-hysterectomy adjustments of black women. Five subscales were used to estimate performance in these five areas and were entered as the independent variables:

- (a) Husband or sexual partner, an 8-item measure;
- (b) Children as support resources, a 12-item measure;
- (c) Female relatives as confidants, an 8-item measure;
- (d) Friends as confidants, a 16-item measure;
- (e) Members of voluntary social organizations, a 15-item measure.

Alphas of .93, .90, .85, .85, and .93, respectively, were reported in a previous study of 120 black climacteric women (Jackson, submitted). Data supporting the provisional validity of the social resource measure were also reported in the earlier study.

### *Analysis and Data*

The sample was divided at the median, on all data available, to create "High" and "Low" groups for each social resource measure. A univariate t-test was then used to evaluate differences between Highs and Lows on Life Satisfaction. In this way, each of the five hypotheses were evaluated for significance at  $p < .05$ . Essentially, these analytic procedures are consistent with an ex post facto design.

## Results

### *Preliminary Findings*

A mean of 25.90, median of 27.57, standard deviation of 7.86, and Cronbach alpha of .81 were found for the LSIA scale on this sample of 89 black hysterectomized women. Table 1 represents the descriptive statistics for the five measures of the Social Resource Inventory Measure, and results in relation to each of the five hypotheses are contained in Table 2.

Hypothesis 1 was supported. There was a significant difference between the means of subjects classified as Lows and Highs. The difference indicating the Highs with more extensive and better quality relationships with their husband or sexual partner have higher levels of Life Satisfaction than Lows who have experienced less extensive and poorer quality relationships with their husbands or sexual partners.

Table 1

Central Tendency and Variability of Each Component of the Social Resource Measure

(N = 89) Social Resource Measures			Standard Deviation	Alpha
	Mean	Median		
1. Husband or Sexual Partner	41.25	44.50	11.17	.90
2. Children as Source of Support	64.04	64.25	14.77	.91
3. Female Relatives as Confidants	35.06	34.16	11.44	.88
4. Female Friends as Confidants	78.98	79.50	15.56	.89
5. Voluntary Social Organizations	68.30	66.75	24.85	.95

Hypothesis 2 was supported. There was a significant difference between the means for subjects classified as Lows and Highs, the difference suggesting that Highs who shared more extensive and better quality relationships with their children have higher levels of Life Satisfaction than Lows who have experienced poorer quality relationships.

The difference between means for Hypothesis 3 as significant. Subjects classified as Highs, who participated in more extensive and better quality relationships with their female relatives, have higher levels of Life Satisfaction than Lows, who have less extensive and poorer quality relationships.

Hypothesis 4, pertaining to Friends as Confidants, was not supported. There was no significant difference between LSIA means of subjects classified as Lows and Highs.

Hypothesis 5, that black hysterectomized women with more extensive and higher quality involvement with voluntary social organizations would have higher levels of life satisfaction than those who did not, was supported.

Table 2

Evaluation of Five Hypotheses Linking Social Resources to Life Satisfaction in a Sample of 89 Black Hysterectomized Women

Hypothesis	n*	Mean	Standard Deviation	t-Value	df	p-Value
1. Husband or Sexual Partner						
Group 1. Lows	24	22.38	9.03			
Group 2. Highs	30	27.40	7.64	-2.21	52	.01
2. Children as Support Resource						
Group 1. Lows	28	23.75	8.61			
Group 2. Highs	19	27.42	9.22	-1.39	45	.04
3. Female Relatives as Confidants						
Group 1. Lows	33	23.61	8.44			
Group 2. Highs	27	28.59	6.66	-2.50	58	.007
4. Female Friends as Confidants						
Group 1. Lows	29	25.24	8.00			
Group 2. Highs	29	26.13	8.70	-0.41	56	.34
5. Voluntary Social Organizations						
Group 1. Lows	36	24.28	8.67			
Group 2. Highs	21	28.22	7.20	-1.70	55	.05

\*The component sums for Highs and Lows do not total 89 because of missing data.

## Discussion

The major findings of this study clearly indicate that a relationship exists between social resources and life satisfaction.

### *Husband or Sexual Partner*

In relation to the first hypothesis, the findings of this study are consistent with both the theoretical literature and empirical evidence. Melody (1962), Raphael (1976), and Webb and Wilson-Barnett (1983) found that supportive intimate relationships are capable of having salutary effects upon the recovery and post-hysterectomy adjustment in hysterectomized women. Melody (1962) found that male intimates who are accepting, approving, and supporting of their hysterectomized partners play an important role in the prevention of adverse reactions, as well as in fostering security and satisfaction.

Raphael (1976) found that, of the 100 Australian post-hysterectomized women studied in relation to social support provided by spouses, the majority of the women reported that they had received adequate support and reassurances that hysterectomy would not make any difference in their intimate relationships from their husbands or sexual partners.

As well, Webb and Wilson-Barnett (1983), reporting on a sample of 95 post-hysterectomized English women, found that women who were positively supported by their partners had greater decreases in mean "Helplessness Self-concept" scores than those who were not supported. This indicates, then, that positive social support from male intimates is of paramount importance in helping women recover their normal behaviour and feminine identity after a hysterectomy.

### *Children as Source of Support*

This hypothesis was supported both by empirical findings and in theoretical literature. Middle-aged women, during stressful times such as serious illnesses, life-cycle change, and loss of intimate relationships, have reported that their children's love and emotional support was able to sustain them until their psychological equilibrium was restored and until new forms of inter-personal relationships were established (Deutsch, 1945; Raphael, 1976).

It is possible that quality of relationships improve as the generation gap between mother and adult child is closed, permitting more emotionally secure and satisfying adult-to-adult attachments. Rodgers's (1980) study is supportive of this view. Interviewing several middle-aged women with respect to areas of the relationship with their children that they found to be satisfying and supporting, she reported

such responses as: "I am enjoying my children now as parent-friend. Since they are older, we can mutually share." "I love my children... I am sure if I were sick, they would be very concerned...", and, "my children have enriched my life enormously. I'd probably be a rigid old housewife without them" (p. 205).

#### *Female Relatives as Confidants*

Black hysterectomized women with more extensive and quality relationships with female relatives reported higher levels of life satisfaction, as predicted. The importance of female relatives is borne out in a study by Nuckolls, Cassel, and Kaplan (1972) who investigated wives in their 32nd week of pregnancy with respect to support from husbands, relatives, friends, and community. They found that relatives were as effective a buffer in reducing stress as were husbands and friends. Raphael (1976) believed that female relatives of hysterectomized women have been important because they served not only as confidants, but also as models for feminine identification. The results of this study, are consistent with those primarily using samples of white women. The cross-ethnic application of the present hypothesis is thus supported and generalizable.

#### *Female Friends as Confidants.*

This hypothesis was not supported. Such a finding was not consistent with the study's conceptual framework, which underscored the importance of friends as an essential component of social network theory. Studies of hysterectomized women, that operationalized the concept "female friends" in terms of social support, provided negative findings in relation to the present study (Raphael, 1976; Webb & Wilson-Barnett, 1983).

This failure could be related to the measure used to operationalize the relationship with female confidants. However another study, which found the expected linkage between relationships to female confidants and life satisfaction, used identical measures to those in this study (Jackson, 1982). The failure could also be related to the sample used. Black women having undergone major surgery might well rely more heavily upon relatives than on friends. Perhaps black women who have not undergone major surgery rely as heavily upon friends as upon relatives, a speculation which only future research can settle.

#### *Members of Voluntary Social Organizations*

This hypothesis was supported and is consistent with studies linking organizational involvement and quality of life at mid-life (Palmore & Luikart, 1972; Tobin & Neugarten, 1961). This linkage is reinforced



by studies that have found that membership and participation in social organizations increases during the middle years (Payne, Payne & Reddy, 1972), that women are more active in church organizations than men, and that their involvement is more socio-emotional than instrumental (Payne, 1975).

#### Nursing Implications for Research, Clinical Practice and Education

The findings of this study suggest implications for research, for clinical practice, and for educational application to nursing. First, the researcher could utilize these findings in future studies. Although the findings are consistent with those reported in the literature for white women, and also affirm a similar pattern between social support variables and life satisfaction for black women, future studies are needed. While it is tempting to speculate that social support may be causally related to life satisfaction, one could also argue that levels of life satisfaction may be causally related to social support. Perhaps this relationship is bi-directional. These possibilities can only be settled by future research.

Secondly, the findings of this study suggest implications for clinical nursing practice. Given the centrality of the uterus and its functions in relation to the feminine self-concept, social roles, and levels of life satisfaction, and since, according to the literature, hysterectomized women are much more vulnerable to emotional disorder, nursing interventions should be directed toward prevention of emotional problems (Melody, 1962). Nurses should establish helpful relationships with their pre- and post-hysterectomized black patients, so as to provide appropriate reassurance and support. They should explore with them latent concerns, unrealistic fears, and misconceptions about the operation, in relation to post-hysterectomy adjustment and sexual functioning, and provide them with concise and concrete factual information.

It has been documented that when planned pre-operative teaching models were implemented by nurses, surgical patients made more positive post-operative adjustments (Ley, 1977). The nurse, however, should carefully evaluate her intervention strategies for black hysterectomized women within the context of complex cultural or sub-cultural life styles, including ethnic, racial, socio-economic, personal, and psychological life history. Differences and similarities inherent in human response to stressful life experiences should also be evaluated.

Patient teaching that is intended to create change must be given at the right time, when the patient is ready, in the right amount, and in the right way (Ley, 1977). By using the patient educational approach

and planning with other appropriate health professionals, the nurse, who is academically prepared in group dynamics and group process, can intervene by introducing and leading pre- and post-hysterectomy individual counselling and group discussion sessions. Knowing that learning and behaviour changes are often facilitated by means of interpersonal processes within small groups, the nurse group leader can help her black hysterectomized patients begin to do early self-appraisal, which has wide applicability for many occasions and types of personal stress.

Another benefit the black hysterectomized patient might receive from participating in pre- and post-surgery discussion groups is exposure to new or alternate ways of thinking about herself, changing her views of herself, or her views of her social environment.

The nurse, as a clinical practitioner, serves in many different roles. One of these roles is that of interpreter for members of the health team, the spouse or sexual partner, and the patient's family. Among members of the health team, nurses are usually the ones who are best qualified for the role of interpreter because of their availability to patients 24 hours per day. They are able to clarify and interpret their patients' behaviours, uniqueness, and sensibilities to other members of the health team and to the patient's significant social network, and to maintain a consistent health care approach. Nursing intervention, then, interrupts and replaces potentially unhealthy behaviour with that which promotes health and a more satisfying way of life for her patients.

Thirdly, literature indicates that researchers have found that hysterectomized women were inadequately counselled by nurses, and strongly recommends that theory content specific to human sexuality should be included in professional nursing curricula (Krueger et al., 1979; Webb & Wilson-Barnett, 1983). Nursing students, undergraduate and graduate, should be knowledgeable about and sensitive to the socio-cultural differences of their female patients. The inclusion of female socio-cultural content in the psycho-educational component of the teaching role of the nurse facilitates competent nursing care delivery.

Finally, the professional nurse must be provided with the knowledge, as well as the skills, necessary to objectively, positively, and sensitively teach hysterectomized patients of various ethnic groups. The nurse must be instrumental in directing patients physical and emotional health, both before and after surgery.

## Recommendations

1. Future studies that would settle questions concerning the bi-directionality of social support and life satisfaction of hysterectomized and non-hysterectomized black women are recommended.

2. Replication studies need to be done, using both larger and more representative samples of black hysterectomized women, from urban and rural geographic areas that would increase the generality of the findings. This was a voluntary convenience small sample, obtained from one urban area in the United States.

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## RÉSUMÉ

### **Être satisfaite de son sort: rôle variable "ressources sociales" chez les femmes noires ménopausées soumises à une hystérectomie**

Les variables "ressources sociales" ont été identifiées comme pouvant éventuellement assurer la médiation du rapport entre la réaction de la femme noire à l'hystérectomie et son niveau de satisfaction face à la vie. Les variables de ressources sociales ont été évaluées en termes d'appui social et affectif apporté par: 1) le mari ou le partenaire sexuel, 2) les enfants dans leur rôle de soutien, 3) les parentes dans leur rôle de confidentes, 4) les amies dans leur rôle de confidentes, et 5) les membres d'organismes sociaux de bénévoles. Les femmes noires ayant subi une hystérectomie ont été définies de la façon suivante: femmes afro-américaines âgées de 40 à 60 ans, nées et élevées aux États-Unis sans hospitalisation psychiatrique connue et ayant subi une hystérectomie simple ou une hystérectomie-ovariectomie. Un dernier échantillon maniable de 89 sujets volontaires a été recruté parmi des femmes afro-américaines répondant aux critères et prêtes à signer le formulaire de consentement; elles ont été retenues parmi un échantillon plus important de 209 femmes noires ménopausées. L'inventaire des ressources sociales de Jackson (1982) dont les 59 éléments ont fourni une gamme de 0,85 à 0,93 de cohérence interne a servi à mesurer les aspects qualitatifs et quantitatifs des relations du réseau, et l'indice de satisfaction de la vie (Life Satisfaction Index A (LSIA)) de Neugarten (1961) en 20 éléments, outil sûr et valable, a servi à mesurer le degré de satisfaction face à la vie. Les données ont été analysées à l'aide d'un test t à variable unique pour déterminer si le groupe ayant obtenu un score élevé et le groupe ayant obtenu un bas score à chacune des cinq composantes présentaient des niveaux de satisfaction différents face à la vie. Les statistiques ont corroboré quatre des cinq hypothèses. Les implications théoriques et cliniques au niveau des sciences infirmières sont proposées d'après ce schème de résultats.