

Psychological Experience of Hemostasis Hysterectomy in Patients at Yalgado Ouedraogo Teaching Hospital (Burkina Faso)

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Abstract: The World Health Organization estimates that approximately 500,000 women die each year during pregnancy or childbirth. In Burkina Faso, according to the 2020 statistical yearbook, in hospitalization, there were 6,116 cases of postpartum haemorrhage and 101 deaths. Haemostasis hysterectomy is a treatment for postpartum haemorrhages. This presents physical and psychological complications in patients. The objective of this research was to investigate the specific reactions of patients from the Department of Gynecology and Obstetrics of the Yalgado OUEDRAOGO University Hospital Center to the announcement of the diagnosis preoperatively or postoperatively, the experience of their own body and the experience subjective sexuality and relationships of these patients. We proceeded by the clinical method through two clinical cases. Interviews and clinical observations were carried out for the collection of data which were analyzed through the technique of thematic content analysis and according to the psychodynamic approach. The results reveal that the patients present a disorder related to the postoperative announcement of the diagnosis such as negative emotions, a disturbance of the perception of the body specific to a type of alteration of perception, and a disorder of sexuality.

Keywords: Hemostasis Hysterectomy, Psychological Experience, Patient, CHU-YO, Burkina Faso

1. Introduction

Immediate postpartum hemorrhage (IPPH) is responsible for 150,000 deaths per year worldwide [10]. Hemostasis hysterectomy (HH) is part of its management. It is a surgical removal of the uterus performed as an emergency measure to control IPPH. Hysterectomy, the removal of all or part of the uterus, is a procedure that involves removal of the uterus body (subtotal hysterectomy) or the body and cervix (total hysterectomy). This mutilating surgery should only be performed as a last resort in the event of a serious parturition accident [12]. For Singhal & al [15], Hysterectomy for hemostasis is an emergency maternal salvage surgery after failure of all the usual means of management of obstetric

hemorrhage.

The IPPH permanently compromises the obstetrical future of the victim and has a high maternal mortality rate [13].

In Burkina Faso, according to the 2020 statistical yearbook, in medical centers and hospitals, there were 6116 cases of delivery hemorrhage and 101 deaths [5]. At Yalgado OUEDRAOGO Teaching Hospital of Ouagadougou (CHU-YO), from January 2020 to December 2021, 06 cases of hemostasis hysterectomy (HH) were recorded in the Department of Gynecology and Obstetrics [19]. Interviews and observations in the said department have allowed us to note that the care of parturients who

have undergone a HH is limited to the medical aspect. For example, Rakototsillavo [14] in his medical thesis analyzed the risk factors of hemostasis hysterectomy in Madagascar. The objectives of her study were to determine the prevalence of hysterectomies for hemostasis at the Center University Hospital of Gynecology Obstetrics of Befelatanana from January 2017 to December 2019, to describe the socio-demographic profile of patients as well as their clinical and paraclinical aspect, to describe the indications and the prognosis of hysterectomy for haemostasis and to identify the main risk factors for hysterectomy for haemostasis. He used a quantitative method of the analytical study type of case-control type, monocentric of the medical observations and the registers of the patients seen in the hospital. The results of the study reveal that multiparas had a much higher risk for hysterectomy for haemostasis, the history of cesarean section influences the practice of hysterectomy in women with PPH. The use of oxytocin constitutes a protective factor. For the etiologies of PPH and the practice of hysterectomy for haemostasis, uterine atony and uterine inversion are not statistically significant. For maternal outcome, the maternal mortality rate is 11.4%. Camara & al. [6] conducted a study on haemostasis hysterectomies in Bamako. The general objective of their study was to study the epidemioclinical aspects and the maternal prognosis of hysterectomy for haemostasis. The conclusions of their study show that HH is the ultimate element of management of postpartum hemorrhage related to uterine atony, uterine rupture or coagulation disorders. It is considered in case of failure or absence of conservative therapies and procedures. Akpa [1] conducted a cross-sectional, analytical study on haemostasis hysterectomy for uterine rupture in Bamako. The objective of her work was to study HH in the obstetrics gynecology department of the Point G University Hospital. The results obtained indicate a frequency of 0.4% of deliveries with HH, i.e., one hysterectomy for 250 deliveries.

The missing link for a holistic and therefore quality health care remains the one inherent to the psychological aspect. Wendland [18] conducted a study on the psychological experience of twin pregnancy by women. Her study examined the particularities of the psychological experience of women pregnant with twins. This study revealed that the announcement of a twin pregnancy is often marked by ambivalence, where joy and fear mingle. However, the reality of the diagnosis inevitably and above all induces a shock effect. Even when the parents were warned of this possibility, particularly in the case of infertility treatment, the announcement of a twin pregnancy is almost always received as a shock by the future parents, with a feeling of incredulity, "of unreality", even amazement. The stressful bodily experience of twin pregnancy can be superimposed on psychological constraints and suffering for the woman, such as the early cessation of all professional activity, the limitation or prohibition of trips and movements that can go as far as to bed rest at home and the resulting social isolation,

as well as near-permanent anxiety about one's own health, growing fetuses, and childbirth. In the event of hospitalization, which can last a few weeks, but sometimes also months, most mothers feel reassured by the supervision, but complain of the lack of intimacy, of loneliness, and are concerned about their partner and their any other children left at home. This experience is particularly agonizing and depressing when hospitalization occurs early in pregnancy and the viability of children is uncertain in the event of premature delivery. She concludes that due to its weakening somatic and psychological experience, twin pregnancy deserves to be considered at high biopsychosocial risk. Touab [17] conducted an observational study of the experience of caesarean section by parturients. The objective of his study was to analyze the experience of anesthesia by caesarean parturients under spinal anesthesia. The method used was a prospective cross-sectional study carried out at the maternity ward of the Mohamed V military training hospital in Rabat, including parturients undergoing caesarean section under spinal anesthesia. The results reveal that caesareans are urgent in 71.3% and 58.7% of parturients were informed about the anesthetic technique. The predominant level of anxiety is the high 48.7%, with predominance of the moments of taking the venous line and spinal anesthesia. Intraoperative pain is found in 21.3%, especially during extraction. The pain is felt strong in 42.67% of cases, moderate in 41.33%, and weak in 16%. Belemkasser [3] in France, analyzed the psychological experience of women giving birth by caesarean section. In her problematic, she approached the experience of emotions and own images solicited by the caesarean section. The results of her work show that the act of caesarean section is experienced differently from one woman to another. Some women present an experience imbued either with guilt, trauma, or with the release of anxiety and the protection of the gendered body. Mathilde [11] has worked on the psychological experience, in particular the problem of the experience and feelings of early miscarriage, mourning, the consequences of miscarriages. Dao and al. [8] carried out a study on the experience of caesarean sections by women in a district hospital in Bamako. The purpose of this study was to study the experience of caesarean section by women. This was a descriptive cross-sectional study with prospective data collection from January 1 to June 30, 2019 with a sample of 234 patients. The results show that the reactions of the patients to the announcement of the cesarean section were fear (53.8%), sadness (25.2%) and relief (21%). Caesarean section was considered good by 85.5% of patients and traumatic by 14.5% of them.

Our study aiming at filling this gap, hence our interest in the psychological experience of hemostasis hysterectomy among patients at Yalgado OUEDRAOGO teaching Hospital in Burkina Faso. In this regard, we intend to highlight the subjective and singular experience of patients after a HH. In a nutshell, our study, through the clinical method under the psychodynamic psychoanalytical approach, focuses on a deepening of the psychological experience issue of patients having undergone a HH.

2. Methodology

2.1. Methodological Approach of the Research

The cornerstone of our research methodology is built around the clinical method in psychopathology and clinical psychology. To do this, we use case studies as one of the means of building and validating hypotheses and interpretations. It is a clinical approach mobilized to study complex phenomena, whether they are numerous or not. It endeavors to provide a detailed and in-depth analysis of the phenomena studied.

The choice of the clinical method as a methodological approach in our research is justified by its originality. It allows, not only, the study of the individual in its singularity and its totality, but also, the production of sound scientific knowledge taking into account its advantage to register all the subjective dimension of the subject. This meaning materializes, to some extent, the relevance that guides our interest in the clinical method of case study.

2.2. Data Collection Techniques

In order to achieve data collection, we use the clinical method "with bare hands". It is specifically to proceed by the techniques of observation and clinical interview because of their reliability and their complementarities in the study of subjects with psychological concerns.

2.3. Ethical Considerations

Prior to conducting the field surveys, all study participants were provided with a Participant Information Note and Consent Form so that they could make a free and informed choice and know what they were agreeing to, by consenting to participate in the study. One of our responsibilities was to ensure that participants understood the wording of the form. To do this, the information on the form was simplified so that the reader understood the meaning and implications of the form. Also, we communicated an honest interpretation of the information provided in the consent form to the participants by describing the procedures, risks, inconveniences, discomforts and benefits of the research. In order to ensure anonymity and confidentiality, we used assumed identities, "Pascaline" and "Audrey" cases.

3. Results and Discussion

3.1. Results

3.1.1. Description of "Pascaline" Case

Pascaline is 34 years old, a housewife, Muslim and mother of 2 children (a girl and a boy). Her husband is 41 years old, electrical worker. The couple lives in Rimkieta. When we spoke with her on March 10, 2022, it had been 14 months since her surgery. Pascaline is the youngest of 8 siblings, including a boy and 7 girls. Died in September 2018, the polygamous father (4 wives) had 15 children in total. Pascaline was met twice for clinical interviews in our office

at the National School of Public Health. She belongs to the Mossi ethnic group, expresses herself spontaneously, easily and is very attentive. She is also relatively easy to talk to, and has a lot of silence breaks during the interviews. At both interviews, Pascaline was properly dressed and had good personal hygiene. Pascaline's pregnancy and delivery went smoothly, as well as birth. She had a wonderful relationship with her other brothers. "In the family we are all from the same mother and father and we have been together since we were children until today" she declares. Her adolescence was marked by illnesses, as she explains: "There were pains in my right side and it used to make me a little tired. I had headaches and also sinusitis. I couldn't go a week or two without saying I had headaches, but with the grace of God, everything is alright".

She then tells us about her school path. Pascaline started elementary school at the age of 7. She repeated the classes of primary 6 (CM2) and form 4 (3ème) and obtained her first cycle study certificate (BEPC) in 2007. She had a daughter in 2008 with a man at the age of 20. Her father was against their relationship, hence their separation. On this subject, she justifies herself:

Because if you don't have a blessing from your parents you can't exist. There was a child, but my father didn't agree to this marriage and I was obliged to do with another man. My daughter who is 14 years old was born from another father.

She adds:

My father did not agree with this marriage and we broke up because it is necessary to leave things as they are and not to force. That's how I had the boy with another man and that was after the customary marriage.

In 2018, the year of her father's death, she gave birth to a boy with another man she met between 2015-2016. From 2016 to 2018, she successfully completed the training of elementary school teachers she paid on her own. About this training, she says: "I had registered in 2016 and from 2016 to 2017, I did the theory component and from 2017-2018, I did the practical component". With a trembling voice and a loaded face, she adds:

I withdrew a little bit because psychologically it's not going well. At this time, I can't be with the children to teach them something, because at any moment the situation can degenerate and it might not be good for them, so I withdrew.

In 2020, she did her customary marriage and the same year, she fell pregnant of the last child whose delivery occurred on 23/01/2021.

The important events in Pascaline's life are illness, meetings, marriage.

The evaluation of her current life shows feelings of helplessness and incapacity in the face of illness, a state of pronounced distress. Her hopes lie in modern medicine and in God. In a faint voice accompanied by tears in her eyes, Pascaline suggests:

Sometimes when you don't have full strength, it's complicated and then you become something else. It is

health before all that you intend to give. If you are not healthy, it is complicated. Sometimes you sit down and you feel weak. If you are healthy, you can go out, you can have fun easily, but if you are not well at home, in your room, what can you think of? Even with your phone and television you can't find your way out. It is the exchanges that will allow you to relax yourself, but once you don't well, how do you manage? That's why I pray God to give me good health because these days..., today it's fine, tomorrow it's not fine. It discourages you more. If you are healthy, you are cheerful with everyone. Wherever you go, people feel that you are doing well and that your health has improved. But if you don't feel well, just looking at yourself makes you want to cry, because you know that something is wrong, but sometimes you deal with it. It's not something you can change in a month. You have to deal with it and give time to time. In the meantime, the movements, sometimes, it's complicated.

Pascaline's comments above indicate a daily experience marked by psychological pain, a painful physical experience and a very low and restricted quality in terms of social networks.

In relation to her pregnancy, while explaining the difficult circumstances that surrounded the beginning of her labor, she also evokes her attachment to her 4-year-old son. Thus, it is animated by a feeling of sadness and sorrow never felt and a feeling of powerlessness that she experienced the situation. She recounts it, moreover, as follows:

The day that I had to go, my 4-year-old child told me, "Mommy, don't go", that if I went, I wasn't going to come back, and I was so sad that I asked him why he was telling me that? And, he insisted that I was not going to come back if I went. And I took out a 100 CFA coin that I was holding and I gave it to him, telling him that, *inchallah*, I will come back. It was around 8 o'clock when I arrived and it was around 3pm, 4pm that the labor started and at that moment the sentence that I had to say there, I told him that I was tired and he told me that it was not the moment, he was telling me that already, I said yes, at a moment I fainted, I don't know at what moment I fainted. What I remember is that when they were taking me out of the hospital and to transfer to Yalgado OUEDRAOGO hospital, I saw people who were not there when I came.

Pascaline ended her words with a sigh followed by silence and then burst into tears. Her experience at Yalgado maternity hospital, particularly in the hospitalization room before entering the operating room, was marked by significant bleeding, several questions and a lot of grief following the death of her baby. She describes the circumstances:

I was sitting down, when I put my hand on my loincloth it was wet. It was not water, but rather blood that was flowing. After that, I saw a lady standing next to me with a chisel and some materials and then she tried to remove something with it, but I didn't know what it was. I don't know if it was the cord and after that I didn't know when I was taken into the block.

Pascaline's experience in intensive care was marked by noise pollution, psychological suffering, questions to which she had no answers and the discovery of the loss of her baby. She describes it as follows:

A moment, what I remember is that I found myself in a room and when I woke up I don't know how long I was there and when I woke up it was the noise of the machines that disturbed me and I did not know where I was. Meanwhile, there was a gentleman who was asking me if I knew where I was. I said that I don't know and that they are the ones who brought me to the intensive care; but there is a voice that told me that my baby is not in this world anymore.

The intensive care situation was for Pascaline a kind of ordeal, a bitter taste, a huge distress with many questions without any answers. As for the discovery of the loss of the child she was expecting, she declares:

There was a voice telling me that my child is no longer in this world. In the meantime, the women who clean were there, and I woke up. There were women who had come to do the cleaning in the morning and when they came, they asked me what was going on and I answered that I didn't know what was going on. What I remember is that I gave life, but there is something that tells me that this baby is no longer of this world. After the operation, a man came into the room and took me to another room.

She ends her remarks with a trembling voice. Following a reminder from us, she tells us about her experience in this other hospitalization room, marked by a very deleterious atmosphere, a bitter feeling, negative emotions accompanying the discovery, in writing, of the loss of her baby. In the end, she falls back on mystical-religious considerations:

It was, therefore, there that the atmosphere was not good at all. I was sitting there, but I didn't know what to do. That's when I believed, but they didn't tell me what was going on. But when they saw me crying, they asked me why I was crying, that my baby did not die, that he was having difficulty breathing, that they were going to take him to the intensive care unit. My concern was that they check if my child was there or not. When I came out, I took the notebook and I saw that there is a stillbirth. When they told me that my baby was in the intensive care unit I shook and shed tears because I knew that God did not allow me to see this baby.

Regarding her reaction to the HH, Pascaline says she felt helpless, sad and shocked, and then relied on God's will to overcome this state. Also, she says:

It was not easy at all for me to accept to go, but you have to deal with it, it is God's will. I was still shocked because what happened to me was not simple. They did everything to hide from me that it was a fibroid and yet the baby was dead, so we had to deal with it.

Pascaline ends her talk in a pleading position and bursts into tears. As for the experience of her body after the HH, Pascaline says she feels physical pain and an empty body. She explains her experience as follows: "It is not easy,

because you know that there is something wrong with your body, you feel an emptiness". Then she adds: "Sometimes you have the feeling that you have infections and that, when you are getting ready to go to bed you are in pain. Sometimes I find it hard to accept, but sometimes I say that only God can do a miracle. She finishes her talk in a low voice and with averted eyes.

In her account of her experience of sexuality, Pascaline experiences a troubled relationship that is difficult to bear. Indeed, she experiences pain during sexual intercourse and even medical visits even though difficulties were not reported after the intervention. Also, she is having a total despair as for the childbirth which she translates as follows: "Today you can make, it does not disturb, tomorrow you make it, you say to yourself that you are going to get pregnant, but after that, it does not work, sometimes it is not simple". She concludes her words with a sigh.

Clinical analysis of "Pascaline" Case:

1) Psychic trauma of the hemostasis hysterectomy diagnostic announcement

The immediate reactions to the announcement of Pascaline's diagnosis reveal the presence of a psychological trauma. This is a type I trauma. The surgical act perceived, sometimes, as an acute stressor, the experience of the hemostasis hysterectomy announcement is, for Pascaline, a unique traumatic event with a clear beginning and a clear end. She presents a psychic trauma characterized by a denial, a state of emotional shock. This state of fear is expressed through symptoms such as great sadness and despair, denial and anger, reliving the event in the form of flashes, a loss of reference points and the meaning of life, physical pain and shame. Those various symptoms are reflected in her words as follows:

It was not at all easy for me to accept, it was a total shock! But, we have to deal with it, it's God's will, I always had a shock because what happened to me was not simple. They did everything to hide from me that it was a fibroid and yet the baby was dead, so we had to deal with it.

Clearly, the psychological shock of the uncontrollable event led to the disorganization of Pascaline's internal world made up of her affective representations. The internal coherence was broken by the disorganizing effect of the event thus causing a psychological imbalance. This imbalance makes the psychological tension unbearable, as it exceeds Pascaline's capacity for emotional treatment. Thus, the disabling event plunged her into a state of intense stress that overwhelmed her. To overcome this state, Pascaline takes refuge in a sublimation, mystico-religious considerations.

The significant life events in Pascaline's clinical picture show that prior to the hemostasis hysterectomy, she had difficult experiences of a traumatic nature. In her story, a life, very early on, strewn with critical events because of their threatening character, the experience of chronic pain in her right flank since her adolescence and the loss of her newborn baby precede the hemostasis hysterectomy. The psychological shock of those experiences would have led to a

weakening of her internal world and caused a vulnerability of her psychic apparatus. That makes the loss of her child, as well as the experience of the loss of her uterus in the same circumstance caused a psychological upheaval due to the complete collapse of her internal world, i.e. her emotional system. But her hope lies in the Supreme Being. This collapse can be seen in her conception of the world and of others when she says: "The most important thing in my life is for God to facilitate, because I feel so small. Today I am not healthy, tomorrow I will be fine. What I want is for God to comfort me".

Finally, it appears that the psychological trauma is characterized in Pascaline by an important state of emotional or psychological shock.

2) Sexual and psychiatric disorders.

Pascaline's clinical picture indicates that she is experiencing an unfulfilled sexuality. The removal of her uterus is experienced as a traumatic event. Depressive episodes, including abulia, apathy, and anhedonia, as well as reduced sexual desire, have a direct impact on Pascaline's sexual functioning. Post-traumatic stress disorder affects Pascaline's emotional and social functioning and can have an impact on her sexual functioning. In her story, she recounts:

..., my wish is to have sex and have children. But, if you do and you can't have children, can you say that you are satisfied? I tell you that it is not easy at all, you have to deal with it...

3.1.2. Description of "Audrey" Case

Audrey and her husband live in the district of Cissin, Ouagadougou. She comes from a monogamous family and both parents are still alive. Audrey is a weaver and her husband is a farmer. She is of Mossi ethnic group and Catholic religion. Audrey is the eldest of 9 siblings, 5 boys and 4 girls. During our interviews, Audrey had a good contact and a sustained attention for the exchanges. We noticed that she had good physical care. Indeed, she has a good physical presentation, especially in terms of body hygiene, clothing and her child. During the two interviews, her clothes were quite neat (clean and well ironed loincloths) as were those of her infant. During our interviews (March 20 and March 31, 2022), Audrey was with her 6-month-old infant. During these interviews, the child kept screaming and crying, disrupting the exchanges. Having allowed the mother to breastfeed her child, we allowed ourselves to observe the interactions between the two. Audrey's behavior was characterized by attentive care.

Aged 35, Audrey is the mother of 6 children, 1 of whom is deceased. Out of the 5 living children, 4 are male and 1 is female. Her child's death occurred in 2019 and was a fresh stillborn, delivered by cesarean section. Audrey describes that when she was born in Ivory Coast, she did not cry immediately and when she tried to put water on her head, she hit a delivery table. She had a harmonious childhood with her brothers and sisters. According to her, she got along very well with her siblings during her childhood. Audrey describes these moments as follows: "We all ate the same

meal, played ball together and went home together".

Audrey entered primary 1 (CP1) at the age of 8 in Côte d'Ivoire in 1995. When her parents returned to Burkina Faso in 1995, she took the same class in the village where she was admitted to the elementary school certificate (CEPE). In the form 3 (4e), she dropped out of school due to lack of financial means. Audrey had her first child at the age of 19 with her current husband. Audrey's adolescence went smoothly, with no sentimental worries, even less a separation in her relationship with her man. The important events of her life are the marriage and the birth of her children. She spends her recreation periods with her family, children and girlfriends as well as at work. Audrey's current life assessment during the interviews shows a good atmosphere in her social relationships. Also, she lies her hopes in God.

She describes her reaction to the diagnosis announcement as follows: "since I wasn't informed that it was a surgery, I wasn't scared, if I was informed, that's when I was going to be scared". Audrey ends her story with a blank stare and then turns back to us, explaining the circumstances under which she knew she had a hysterectomy. A circumstance marked by pain, sadness and also joy. For this end, she reports as follows:

When they removed the disease, they told us to go to Schiphra Hospital to see and do some tests. They didn't tell us what they removed. A few days later, when my husband sent the results of the anatomopathology, the doctor asked me how many children I had and I said 6 and he said that I was lucky, otherwise I could not have any more children. When I found out about this, I was not happy, I felt bad, but not too bad. As I already have 6 children, it didn't hurt me much and I thank God. I was told that I cannot have any more children. Afterwards, I informed my husband and he told me that since I am alive, that is the most important thing.

In a low voice, Audrey concludes her story with an air of amazement and surprise.

She was traumatized by the diagnosis and is still reliving the situation. The fact that she has living children, the belief in a Supreme Being, comforts her and relieves her of the suffering she endured. She says, "If I think I have up to 5 living children, I am happy. But I don't forget when I think about it. I thank God that I am alive". Audrey feels ashamed of the people around her who know her current status. In a low tone and with a shifty look, she says, "It is my husband alone who knows that my uterus was removed, even my mom and dad, I didn't tell".

Going back once again to her reaction to the diagnosis announcement, she confesses, always in a low voice: "When I am sitting alone, I remember and I am sad". At that moment, her only support is her husband: "When my husband sees me like this, he tells me to forget and to thank God, because I am alive". The couple relies on God during those trial moments.

When dealing with the experience of the body, after a long silence, until we recalled the instruction, Audrey expresses herself in a calm voice tone and with her gaze lowered, "I still have pain, but it's a little better". In addition, she admits that her pain is more intense in her stomach: "my stomach

was hurting, especially in my lower abdomen, but now I'm a little better". With her right hand, Audrey points to her pelvic area. Afterwards, she reports urinary problems following the surgery. She gets up from her chair and says in a laconic way: "I urinate too often". She finishes her story with a crumpled face and an evasive look.

Regarding her sexual experience, in a calm voice and with a fixed gaze, right in the eyes, Audrey declared that she had a satisfactory sexual relationship with her husband: "My sexual relationship is satisfactory and there are no problems". After a long silence followed by a reminder from us, she admits that her sex life is disturbed, unlike the period before the surgery. She explains her feelings as follows:

We used to have sex at least 3 or 4 times a day during the week. Everything was fine, I was happy. But now my husband can go 3 months without touching me. I don't have the same feeling as before. I don't have too many problems with it. I don't complain too much. Since I already have 5 living children, there is no problem. I am alive and that is enough for me.

At the end of the two interviews, Audrey said that she had found a certain interest in the exchanges and added that she felt a little relieved.

Analysis of Audrey's case:

- 1) Postoperative announcement of hemostasis hysterectomy and negative emotion (emotional ambivalence): fear and feeling of death

The analysis of Audrey's clinical vignette shows that she has post-traumatic stress disorder. The post-delivery hemorrhage and coma are life-threatening for the mother. This situation translates into a feeling of real or imaginary threat to the physical integrity of the individual, a feeling of intense fear, a feeling of helplessness or horror, a loss of control of the situation by the individual. All of these causes led Audrey to experience a psychic upheaval expressed by a feeling of chaos and disturbances of self-perception and even depersonalization. This is a sign that, faced with the intensity of her emotions, Audrey's psychic capacity is overwhelmed.

The anguish, the pain of pregnancy and childbirth, the perilous circumstances of childbirth and the announcement of the diagnosis are the etiology of this psychotrauma in Audrey. She translates it as follows:

I had severe bleeding and fell into a coma. Afterwards, the ambulance was called and they came to take us and sent us to Yalgado. I continued to bleed at Yalgado and at a moment the medical team decided to take me to the operating room.

Post-traumatic stress disorder had several manifestations in Audrey. Audrey's reliving is remarkable. She relives the hemostasis hysterectomy persistently through repetitive and intrusive memories. She expresses it this way: "When my husband sees me like this, he tells me to forget about it and to thank God, because I am alive. In addition to the revivals, Audrey also has a reaction of powerlessness, of loss of her state control. As for her mystical-religious considerations, they are expressed as follows:

There are times when I think about the disease. I thank

God for making me alive. Before, I didn't feel well, but I didn't feel well to get up than to go to bed.

Shortly after the traumatic event, Audrey experienced a period of emotional amnesia or psychic blunting, which corresponds to a decrease in reactivity to the outside world. This is reflected in a marked decrease in interest or participation in activities that were previously sources of pleasure, a decrease in emotionality and a reduced projection into the future. A feeling of anxiety is also apparent in Audrey. In this regard, she maintains:

After my delivery, I could not breastfeed my baby, I could not do anything. I did 4 days without being able to get up and feed my baby. I was tired and couldn't sleep well.

These manifestations resulted in a disruption causing an alteration in Audrey's social functioning. These relate to anxiety, depression, difficulty concentrating and sometimes inappropriate social behaviour (isolation) as well as certain other psychological disorders such as sleep disorders and exhaustion.

2) Physical Body and somatic disorders following hemostasis hysterectomy

Audrey's pregnancy, delivery and hysterectomy were fraught with physical pain and suffering. Audrey has physical complications such as pelvic pain and urinary problems. She expresses it as follows: "my stomach used to hurt, especially in the lower abdomen, but now I'm a little better" and "I urinate too often". These prolonged physical pains create a neuro-vegetative activation and a state of distress.

She also has psychological problems such as sleep disorders and exhaustion. The loss of the uterus causes Audrey to have brief and repetitive flashbacks. The absence of the uterus provokes a feeling of shame towards those around her and she expresses it as follows: "it is my husband alone who knows that my uterus was removed even to my daddy and mommy, I didn't tell".

3) Sexuality disorders (sexual dysfunction) and hemostasis hysterectomy.

Traumatic life events, including a hemostasis hysterectomy, can impact sexuality by making it feel negative, dangerous, or repulsive. Audrey's subjective experience is one of disrupted sexuality following a hemostasis hysterectomy.

3.2. Discussion

Through this study, we first got to the result that the postoperative diagnosis announcement creates a reaction of emotional shock, fear and a traumatic reaction in the patient. The experience of the patients' body is marked by physical pain and the loss of an organ, which leads to psychological suffering. The subjective experience of the patients' sexuality is marked by disorders, as shown by the case of Pascaline.

Beltran [4] in his work found similar results to ours. In his study, he shows that in the postoperative period a number of women will express complaints linked to the hysterectomy that often reveal anxious manifestations such as fatigue, gastrointestinal disorders, palpitations, anxiety attacks, decreased libido, and may go as far as a phobia of penetration.

Cishahayo [7] in his study on the psychological experience of recently operated patients also came to the same conclusion. For him, the patient becomes aware of all the physical changes brought by the operation, they experience upheaval and loss of self: stress in the face of various events, anxiety about the future, alteration of the body image, psychological suffering.

Faure [9] also reached similar results to ours. The results of his study showed that embolized patients have a feeling of death, a feeling of helplessness and extreme fear. Following this event, some women seem to have periods of reliving the event through nightmares and flashbacks. They describe psychological suffering and seem to avoid anything that might remind them of the event. Some patients would still present persistent physical and psychological after-effects several years after their delivery. Faure [9] also found that the physical, psychological and social states described by the patients were associated with the definition of post-traumatic stress disorder (PTSD). Thus, his results reveal that the majority of patients who had a delivery hemorrhage resolved by uterine artery embolization had PTSD following this event.

Therefore, we conclude that the announcement of the diagnosis to the patients is made post-intervention and that their reactions are marked by a state of emotional shock and fear.

Bâ & al. [2] also found results similar to ours. Firstly, they mention the absence of an adequate and well identified setting for the announcement: sometimes it is in the doctor's office, sometimes in the corridors of the hospital. Secondly, their results attest to an intense emotional shock felt at the time of the announcement for most patients. They also noted particular attitudes of the physicians that reflected their discomfort. Moreover, it appears that the patients wish to be informed about their disease, the therapeutic possibilities, the evolutionary modalities and the side effects of the treatments.

The results of the diagnosis announcement show that it is made post-intervention. Tchaou & Zoumenou [16] reach the same result in their study. They report that out of a total of 108 patients scheduled for surgery, 45 patients (60%) did not receive information about the procedure they were to undergo and 60 patients (80%) were not informed about the possible complications of surgery. However, 58 patients (77.3%) were informed of the anesthesia technique. Yet, several psychoaffective signs were observed. Thus, 32 patients were afraid of dying (42.6%) and 37 patients (49.3%) had experienced anxiety.

4. Conclusion

The objective of this study, with a clinical approach, was to learn about the psychological experience of patients who had undergone a hemostasis hysterectomy. By means of interviews and clinical observation, we collected data on 2 clinical cases who freely consented to participate in the study. Content analysis was applied to the data collected, following a psychodynamic-psychoanalytic approach. At the end of this methodological approach, it comes out that the patients' reactions to the diagnosis announcement are essentially the

emotional or psychological shock generated by a type 1 trauma. The study also shows that the subjective experience of the patients' own body is made of physical pain and loss of femininity. The study also shows that the subjective experience of the patients is marked by sexual disorders.

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