

HYSTERECTOMIES AND GENDER IDENTITY

AMONG SERBIAN WOMEN

A Thesis

by

MASA SUKOVIC

Submitted to the Office of Graduate Studies of
Texas A&M University
in partial fulfillment of the requirements for the degree of

MASTER OF ARTS

August 2007

Major Subject: Communication

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ABSTRACT

Hysterectomies and Gender Identity

Among Serbian Women. (August 2007)

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Chair of Advisory Committee: Dr. Barbara F. Sharf

In this qualitative study, I explore the impact of national culture on the gender identity of Serbian women with hysterectomies, with special emphasis on traditional motherhood discourse and its implications for women who cannot bear children. More specifically, I investigate how women who have undergone hysterectomy (surgical removal of part or all of the uterus) perceive themselves after the surgery and how that perception influences their sense of self, gender identity, and sexuality. Finally, I examine how these women communicate their gender identity to the people surrounding them, especially current and potential romantic partners, and how communication with their relational partners and others in their respective communities can help improve or diminish their emotional status after hysterectomy.

In this report, I identify and analyze the following themes which emerged from the data gathered through my in-depth interviews: Serbian culture of imperative motherhood; the role of relational partners; Serbian women's health beliefs and practices; spirituality and religion in relation to hysterectomy experience; the role of social networking in the lives of Serbian women, and stigmatization and stigma potential. These six prominent themes are all embedded in the fabric of Serbian culture and represent the summary of most common reactions, fears, anxieties, problems,

attitudes, and beliefs Serbian women with hysterectomies may experience before or following the hysterectomy procedure.

This study identifies ethnicity and nationality related issues influencing women's hysterectomy experience and the experience of their partners, i.e., takes important cultural factors into account, analyzes them, and identifies social, historical, and cultural reasons for their existence. Furthermore, the current study identifies and provides explanation about the role of the social community, especially the roles other females play in influencing the attitudes of women with the lived experience of hysterectomy and the impact other women's attitudes may have on their gender identity. Finally, the current study recognizes the necessity for improvement of health services offered to Serbian women with hysterectomy experience and especially the importance of establishing support and self-help groups to help women deal with hysterectomy related issues, such as fears, anxieties, insecurities, communication problems, and impaired gender identity and gender identity shifts.

To my mother

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CHAPTER I

INTRODUCTION

In one of the episodes of the *The Simpsons*, entitled “Children of a Lesser Clod” (the title is a parody of the 1986 dramatic film “Children of a Lesser God”) Homer ends up hurting his leg so badly that he requires surgery. While watching the procedure with Homer lying on the operating table, surrounded by a nurse, a surgeon, and an orderly, daughter Lisa remarks on the scene to her mother Marge, “So many times we’ve seen our father go under the knife.” Marge replies in a carefree, even ecstatic way, holding up a card: “One more and I get a free hysterectomy!” (IMDB, 1990).

In spite of what the witty creators of *The Simpsons* and other aspects of the world of popular culture tell us about women and their reactions to health-related challenges, it is highly unlikely that a reaction like Marge’s would be reiterated by many women facing the possibility of undergoing a hysterectomy procedure. In accordance with what Nancy Tuana (1993) refers to as “common core of shared [female] experiences,” many women anticipating or having undergone surgical removal of their uterus experience feelings of loss and contradictions or shifts in gender identity. This study will focus on reactions to hysterectomy in Serbian women. It begins with my own experience.

When I recently saw the episode of *The Simpsons* again, the “hysterectomy gag” made me laugh out loud, but it also made me feel strangely uncomfortable for it instantly reminded me of four Serbian women very close to me, three of whom are my family members, and their experience of hysterectomy. I am myself a woman who belongs to the Serbian culture and therefore have an immediate interest in the position of women in

Serbian society, but my very personal connections to the topic I analyze in my thesis, i.e. gender identity and hysterectomies among Serbian women, and my relationship with these four women made me choose this particular topic in the first place. All four responded to their hysterectomy experience in a very different way and their reactions drew my attention to the fact that hysterectomy is a really “big deal” when it happens in Serbia, mainly due to the cultural patterns of imperative motherhood prevalent in Serbian highly pronatalist society.

One of the women who inspired me to pursue my research interest was Andja, one of my mother’s married aunts from Serbia. As a young woman she underwent a hysterectomy procedure due to two ectopic pregnancies, the second of which was followed by excessive bleeding and pain, after which her doctor advised that a hysterectomy should be performed urgently. She had the full support and love of her husband whose only concern was not losing her, regardless of whether they would ever have children. Since she had no children before the procedure and became sterile due to her hysterectomy, she and her husband remained childless. For that reason, they practically adopted her sister’s two daughters, whose father died in their early childhood and whose mother suffered from a chronic illness. Even though two girls did not live with them, they visited on regular basis and spent vacations and holidays with them. Andja was a very important figure in their lives and they always thought of her and her husband as their “second mother and father.” After her loving husband’s death, which shook her to the bone, Andja spend a lot of time taking care of my brother and me. She was a wonderful granny to us and I always remember her as one of the most positive,

caring, and affectionate people I have known in my life. Even though she was not given an opportunity to become a biological mother to a child of her own, Andja spend most of her life being a nurturer and a “second mother” to everyone she loved, which made her truly happy and satisfied with her life. Additionally, due to her excellent communication with her husband, she managed to reconstruct and maintain her female identity as well as her sanity.

On the other hand, Milka, my mother’s other aunt, found herself in a virtually identical medical situation where she had to go through a hysterectomy because of large, rapidly developing uterine fibroids, due to which she became sterile. Unlike Andja, who remained happily married following her hysterectomy, Milka was subsequently abandoned by her husband who left her for another woman with whom he could have children. As a result, Milka experienced several serious mental disorders, was diagnosed with paranoid psychosis, confined to a psychiatric institution for a short period of time, and remained on antidepressants for the rest of her life. The only ray of light in her otherwise tragic life was her husband’s illegitimate son whom she treated as a child of her own. So strong was this bond that was created between them and so strong her love and affection for this child that he accepted her as his biological mother and publicly talked about her in that way, while his actual mother played a subordinate role in his life. By the end of her life, my mother’s aunt suffered from many serious ailments, including diabetes, Parkinson’s disease, and more instances of paranoid psychosis, which she could control by constant intake of medications. My mother shared with me a memory of her aunt lying in a hospital bed after falling down in the bathroom and breaking her arm,

and not recognizing anyone, including her brother's children, except for her stepson. Until the last day of her life she worried about him and took care of him, as if he was her own child and more than that—an answer to her prayers. My mother told me that her aunt thought of her stepson as the child she should have had with her husband, and in many ways he was just that.

A third reason I was particularly intrigued by and compelled to analyze the connection between hysterectomies, gender identity, and culture was that a very good friend of mine, a young, unmarried, heterosexual Serbian woman residing at College Station recently had a total hysterectomy, i.e. had her uterus removed as well as one of her ovaries due to uterine cancer. She did not have any children prior to the procedure, and as a consequence of it, had no possibility of having biological children of her own. . We talked daily, and she shared her experience and her pain with me. She was very strong and very rational about what was happening to her; she refused to feel sorry for herself and would not let anyone else do so either. I thought that I could never be like her in a similar situation. Not only was this a life-threatening situation; it was also a situation in which she was in danger of losing her female as well as her cultural identity, having in mind the great importance placed on motherhood in Serbian culture. I think on many levels I was more afraid than she was. Why was it so? The situation with my friend brought back memories of my family history of hysterectomy and made me genuinely afraid for myself. It may sound selfish, but even though I was empathizing greatly with my friend's situation, trying to be as helpful as possible under the

circumstances, I kept thinking about how I would behave under similar circumstances, and I was not happy with the answer to this question.

Yet the hysterectomy episode that came closest to me was my mother's experience of hysterectomy. My mother had a partial hysterectomy in the summer of 1998 due to cancerous cells doctors found on her cervix following abnormal Pap smear results. For more than eight years I refused to remember how lost I was when I was told that my mother had what they call "the worst thing of all" in Serbia, that she had to go to the hospital for an operation "and then we'll see what we'll do next." I refused to remember how I offered my prayers to whichever deity was willing to embrace them for whichever price it required, and how raving mad and utterly miserable I felt while waiting for the results of the biopsy and for my mother to come home. I refused to remember how the hospital reeked of stale urine and watered down instant soup and death poorly masked in white coats and protective gloves. I chose to forget all these because it was simply too hard to think or talk about it; however, it feels liberating and healing to write about it here instead. Even though my mother is today a cancer survivor and her cancer was discovered at an extremely early stage, at some deep level for me the idea of removing the uterus and ovaries became linked with cancer, loss, and danger. Reflecting on all these life experiences, I realized that I myself am not afraid of death, but of bodily decay, stigmatization, and possible social rejection. In other words, I chose the topic of hysterectomies and female identity for my thesis out of sheer fear more than for any other reason. I felt the need to explore my fear further because I was deeply troubled by it and decided to explore this, for me highly problematic, matter in my

thesis. While working on this thesis, my fears have been re-awakened, but I cherish the sense of absolution that exploring them and writing about them have given me. I feel steadier, more serene, and more complete now. I had been afraid to remember and deal with my mother's hysterectomy, afraid to analyze my own feelings about it, and afraid to contemplate the possibility that I might, one day, due to the laws of heredity, find myself in a situation similar to the one my mother faced almost nine years ago. In spite of my immense feeling of uneasiness or maybe because of it, I knew I needed to face and embrace my fear, and ultimately deal with it through the self-healing, sense-making, and therapeutic process of writing my masters thesis.

A famous Serbian writer Milorad Pavic, who was nominated for the Nobel Prize in literature, once said he believed the novel is a kind of cancer—it lives off its own metastasis. That is certainly the case with the story presented here, which was, in a way, fed by my mother's and my friend's instances of cancer, their subsequent hysterectomies, my family history of hysterectomies, my cultural heritage that places so much emphasis on being a mother, and my fear of having to go through a similar experience one day. In addition, in one of his novels, Pavic writes: "One of the certain ways into the true future (for there are false futures as well) is to go in the direction in which your fear grows." That is what I decided to do. I followed my fear to see where it would take me. It took me to a place where, after more than eight years, I am no longer afraid.

1.1 Definition of Terms

1.1.1 Hysterectomy

Hysterectomy as defined by *Webster's New World Medical Dictionary* is: "A surgical operation to remove the uterus and, sometimes the cervix [the lower, narrow part of the uterus]. Removal of the entire uterus and the cervix is referred to as a total [or radical] hysterectomy. Removal of the body of the uterus without removing the cervix is referred to as a subtotal [or partial] hysterectomy." In popular and sometimes even scholarly usage, there is at times confusion about which exact body parts are removed during the hysterectomy procedure. As Elson (2004) explains, "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" (p.3).

Additionally, as a result of hysterectomy, a woman's reproductive ability is curtailed, which may disrupt her "self-concept of 'femininity' due to the central role of the uterus in the development of women's perspectives regarding body image, social role, and gender role" (Wolf, 1970, p. 165). Therefore, "women who have undergone hysterectomy may consequently see themselves as defeminised by having a hysterectomy" (Wolf, 1970, p. 165).

1.1.2 Personal and Gender Identity

In the glossary of *Sex Research, New Developments*, John Money (1965), who made a significant contribution to the development of early theories of gender identity, defines *gender identity* as:

The sameness, unity and persistence of one's individuality as male, female (or ambivalent), in greater or lesser degree, especially as experienced in self-awareness and behavior. Gender identity is the private experience of gender role, and gender role is the public expression of gender identity.

Even though Money was a pioneer in his field and identified a number of influential concepts and terms during his career, and is thus worth mentioning here, his definition of gender identity and his accompanying research have been frequently challenged by other researchers, have come under intense criticism in the scientific community, and were ultimately replaced by other concepts. Competing theories of gender and definitions of gender identity, such as those put forward by Seyla Benhabib, challenge his views substantially and I will be using these latter definitions in this report, as they correspond to my research purposes more adequately.

Benhabib (1999) analyzes how we can think of sexual difference in the context of new struggles around collective identities, and discusses the concepts of gender/personal identity from the narrative point of view, referring to it as “the narrative model of identity.” She asserts that:

To be and to become a self is to insert oneself into webs of interlocution: it is to know how to answer when one is addressed; in turn, it is learning how to address

others. [...] We are born into webs of interlocution, or into webs of narratives—from the familial narrative to the linguistic one to the gender narrative and to the macronarrative of one's collective identity. We become who we are by learning to become a conversation partner in these narratives. (Benhabib, 1999, p. 225)

Furthermore, Benhabib (1999) defines personal identity as the “ever fragile achievement of needy and dependent creatures [i.e. humans in general] whose capacity to develop a coherent life-story out of the multiple, competing, and often irreconcilable voices and perspectives of childhood must be cherished and protected” (p. 230). Moreover, Benhabib emphasizes that, “Furthering one's capacity for autonomous agency is only possible within a solidaristic community that sustains one's identity through listening to one and allowing one to listen to others with respect within the many webs of interlocution that constitute our lives” (1999, p. 230). Finally, she concludes that, according to the narrative model of identity, “identity does not mean “sameness in time” but, rather, the capacity to generate meaning over time such as to hold past, present, and future together” (Benhabib, 1999, p. 233)

From a communication perspective, personal identity may be perceived as the ultimate rhetorical strategy (Burke, 1950). In *The Rhetoric of Motives*, Kenneth Burke illustrates his notion of the social function and the central role of identity, claiming that identification locates persuasion within a context of mutual inquiry and knowledge creation (Burke, 1950). In other words, each individual identifies herself in reference to other people, their interests, their desires, and their values, or, to phrase it differently,

people construct their identities by comparing themselves to others and by defining what they themselves *are not*, rather than what they *are*.

1.2 The Purpose and Objectives of the Study

As previously stated, in my study I chose to focus on Serbia primarily due to the fact that I myself am a Serbian woman who shares the Serbian culture and therefore has a personal interest in the female question in Serbian society, as well as my other, personal connections to the topic I analyze in my thesis. Some of the complicating factors, such as the culture of imperative motherhood, general lack of interest in women's health-related issues, as well as the appalling lack of hysterectomy-related statistics available in Serbia, assured me that the hysterectomy issue in Serbia should be given more attention and exposure, and prompted me to address this issue in more detail. For all these reasons I chose to explore the case of Serbia, using a qualitative analysis of women's narratives about their lived hysterectomy experience. In addition, I wish to consider the pattern of emphasis on maternity in the traditional culture of the Serbs: its pivotal role in Serbian strongly pronatalist society, where "motherhood [is seen] as imminent, natural, and universally expected from all women" (Remennick, 2000, p. 839); the heroic character of birth-giving, and glorification of the mother accompanied by a great number of beliefs, magic activities, and rituals associated with specific historical and social circumstances, especially a great number of wars on the Serbian territory; and the resulting significant decrease in population and the need for bearing more children in order to keep the nation alive. All these factors make the Serbian

situation and the hysterectomy experience of Serbian women even more specific, interesting, and worth analyzing.

In my research about Serbian women and how they cope with hysterectomy, I focus on the ways in which their body image formations and, more importantly, their senses of self are related to disease, femininity, culture, sexuality, partner communication, and identity dilemmas. To do so, I analyze narratives of sixteen Serbian women who have undergone hysterectomy and each individual's uncertainty about her sense of self based on the social construction of the feminine and femininity in the Serbian patriarchal society; in other words, who they believe they are versus the labels ascribed to them by the society in which they live. My immediate goals include identifying and analyzing the ways in which their individual attitudes, cultural patterns, and communication with their relational partners may or may not affect personal and/or gender identities of women who have undergone hysterectomy. Furthermore, I wish to draw the attention of the scientific public to the fact that in many areas of the world, including Serbia, emotional dilemmas and possible identity crises in relation to cultural patterns and partner communication in women following a hysterectomy have been under-recognized and under-researched, and that these issues need to be addressed and possible remedies identified. Moreover, I wish to emphasize the lack of adequate psychological support for these women in Serbia and the necessity of developing satisfactory programs, such as support groups and counseling for women prior to and following hysterectomy procedure, in which women can communicate and get advice from trained experts, as well as from other women who have gone through a similar

experience. Finally, one of my goals is to provide more visibility to the voices of these women in the hope that eventually greater attention will enable women who go through hysterectomy to better negotiate their multiple identities and/or identity shifts that occur as a consequence of this procedure.

1.2.2 The Hysterectomy Issue

In the United States hysterectomy represents the most frequent non-obstetric surgical procedure among women; the U.S. hysterectomy rate is among the highest in the developed world, with approximately 633,000 hysterectomies performed in year 2000 (Brett & Higgins, 2003). While official statistics about the number and nature of hysterectomies performed are readily available to both the scientific and non-scientific communities in the USA through a number of public institutions and academic and non-academic publications, such official, easily obtainable statistics, to the best of my knowledge, cannot be acquired in Serbia. Furthermore, while many studies have been conducted in the U.S. to examine not only medical, but also social, psychological, and, more rarely, communicative aspects of hysterectomy, in the case of Serbia the focus of the existing research has been mainly on the medical side of the women's hysterectomy-related experience, with only one study identified that deals with the psychological aspects of hysterectomy. Zlatanovic (2001) briefly explores the influence of hysterectomy on women's emotional or psychological well-being and quality of life, but fails to take either cultural or communicative issues into consideration.

During my two visits to Serbia in May 2006 and May 2007, I made a considerable effort to gather statistics on the number and nature of hysterectomies

performed annually or any other kind of statistical data related to this issue, but was faced with considerable problems in obtaining them. Through direct communication with the official Serbian institutions, such as the Serbian Ministry of Health and the Institute of Public Health of Serbia “Dr Milan Jovanovic Batut” in May 2007, I was informed that such data simply do not exist on a national level for Serbia, but potentially can be obtained only from individual institutions, such as public hospitals and clinics in various Serbian cities and towns. However, a clear picture and precise number of hysterectomies cannot be obtained even if the official data existed and were readily available at public hospitals and clinics because a great number of private clinics and private practitioners in Serbia perform a large number of these and other gynecological procedures, and do not forward their data to the public and state institutions as they are supposed to.

Through my extensive research based mainly on the materials offered by the National Library of Serbia, as well as my direct communication with one of the rare Serbian experts in this area willing to cooperate and provide me with official data, Prof. Dr. Tihomir R. Vejnovic, the president of the Gynecological Section of the Serbian Medical Society and Head of the of the Gynecological Clinic in Novi Sad¹, I managed to gather enough data to provide an approximate illustration of the number and type of hysterectomies performed in several larger health institutions in Serbia. According to Jovanovic (2000) at Gynecological Clinic “Narodni Front” in Belgrade, the capital, radical (total) abdominal as well as vaginal hysterectomies have been performed since

¹ Novi Sad is Serbia’s second largest city, after Belgrade, the capital.

the founding of the clinic in 1995. Between 1955 and 2000 several thousand hysterectomies have been performed. For example, in the decade between 1985 and 1994, a total of 610 radical hysterectomies had been performed at Gynecological Clinic “Narodni Front” in Belgrade. The total number of gynecological operations at the clinic in the same period was 20170, which means that the percentage of hysterectomies is 3.02% of the total number of gynecological operations performed at this institution (see Table 1) (Jovanovic, 2000). Radical hysterectomies are performed at the Gynecological clinic in Novi Sad as well. According to Draca (1977, 1989), in the period between 1963 and 1968, 97 women were operated on at this clinic; in the period between 1969 and 1975, 133 women had hysterectomies; while in 1989, 319 women had a radical hysterectomy at this institution.

Table 1

Radical (total) hysterectomy at Gynecological Clinic “Narodni front” in Belgrade

Year	Total number of gynecological surgeries	Radical hysterectomy	Percentage
1985	1,778	59	3.3
1986	1,937	61	3.1
1987	1,978	64	3.2
1988	1,952	63	3.2
1989	2,048	52	2.5
1990	2,261	45	2.0
1991	2,108	70	3.3
1992	1,970	70	3.5
1993	1,928	52	2.6
1994	2,210	74	3.3
Total	2,0170	610	3.02

Note. The data on radical hysterectomy are adapted from “Radikalna histerektomija i urinarni trakt” by R. Jovanovic, 2000, *Urološka ginekologija*, Medicinski fakultet, pp. 171-178.

More recent data show that in the period between January 1 and December 31 2006, 252 total abdominal hysterectomies and three subtotal abdominal hysterectomies were performed at the Gynecological clinic in Novi Sad, while, in the same period, 92 vaginal hysterectomies and two laparoscopies (one total and one subtotal hysterectomy) were performed at the same clinic (see Table 2) (Segedi et. al, 2006).

Table 2

Abdominal hysterectomy, vaginal hysterectomy, and laparoscopy at Gynecological Clinic of Clinical Center in Novi Sad in 2006

Type of surgery	Number of surgeries	Time frame
Abdominal hysterectomy	255 (252 total and 3 subtotal)	1/1/2006-12/31/2006
Vaginal hysterectomy	92	1/1/2006-12/31/2006
Laparoscopy	2 (1 total and 1 subtotal)	1/1/2006-12/30/2006

Note. The data are adapted from “Godisnji izvestaj operativnog odeljenja klinike za ginekologiju i akuserstvo Klinickog Centra u Novom Sadu,” by Prof. Dr. D. Segedi et al., 2006.

At the Institute for Gynecology in Belgrade more than a hundred hysterectomies are performed annually, while a considerably smaller number of these procedures are done at gynecological clinics in two other major Serbian cities, Nis and Kragujevac (Jovanovic, 2000). Clearly, the above stated data are very few and random, and do not represent the realistic picture of the number and type of hysterectomies performed in Serbia, especially since the procedures performed in private clinics and by private physicians are not included because most of them do not forward their data to the public

and state institutions as they should. On the other hand, the very fact that there are no official data about the number and type of hysterectomies performed annually on the level of Serbia indicates that further research on this matter is pivotal to shed more light on the situation of women with hysterectomies in Serbia.

1.2.1 The Status of Women's Health in Serbia

According to the "Action plan for maintenance and improvement of women's health in Serbia for the period between 2005 and 2010" developed by the Autonomous Women's Center from Belgrade, the Women's Center from Uzice, and the "Women in Black" organization from Belgrade, some of the strategic goals for these groups are to provide availability of quality health services to all women and to increase the influence and active participation of women as users and members of local communities in decision-making concerning planning and creating health politics in the country. The latter, among other things, includes popularization and formation of self-help groups which connect women with others who are facing or who have faced the same or similar types of crisis in life, such as for women who have had a mastectomy, women victims of family violence, and women with gynecological problems. Such self-help groups have been successful in the U.S. for decades but are still very novel in Serbia. As authors of the Action plan state, women's health includes emotional, social and physical benefits, and is equally determined by the social, political, and economical context a woman lives in as it is by the biological qualities. However, the health system in Serbia in the great majority of cases does not provide an adequate solution for women's health-related issues because it does not take into consideration specific gender characteristics that

determine women's health. Instead, the most frequently offered health services for women are focused solely on reproductive health and the role of women as mothers, which is a pivotal, even mandatory role for women. Serbia is a highly pronatalist society in which "childlessness (even involuntary) is sometimes treated as a form of social deviance" (Remennick, 2000, p. 822).

In Serbia female citizens compose 51.4% of population, based on the data from the last census conducted in 2002. Their average age is 39 and of all women older than ten years of age, 5.7% are illiterate, while one fifth (21.7%) of the illiterate women are over 65 years of age, a statistic that greatly influences not only their social status but also their health condition ("Akcioni plan").

Social elements, such as personality and surroundings, as well as family and community play an important role in the way a woman leads her life, sees herself, and solves problems related to her mental and physical health. A lot of women in Serbia perceive their deteriorating health as something normal, without paying attention to their symptoms, because they are expected to fulfill many social and family obligations dictated by the cultural climate and social circumstances. This kind of attitude of women towards their own health is reinforced by cultural taboos and prejudices, which enforce the belief that women's health-related and other problems are a direct result of their own behavior and actions ("Akcioni plan").

A significant improvement in the general state of public health of Serbian citizens, including females, took place in the second half of the twentieth century, and was mainly manifested in a decrease in mortality caused by infectious and parasitic

diseases, maternal and infant mortality, and an increase in life expectancy. However, in the early 1990s, a deterioration in the general state of the health of Serbian citizens began to occur, as a direct consequence of the cumulative effect of a great number of critical events to which the population was exposed, starting with the breakup of the former Yugoslavia and a number of wars in its territory (1991-1995), economic sanctions enforced by the international community followed by hyperinflation and grave economic crisis, as well as NATO air strikes on Serbia in 1999. The status of health was additionally jeopardized by risky behavior and life styles, recklessness towards the natural environment and pollution, as well as poverty and unemployment resulting from the long-lasting economic crisis. Furthermore, a great influx of refugees and internally displaced people from Kosovo resulted in a significant change in health status in Serbia. (“Akcioni plan”).

The necessity for improving the status of women’s health in Serbia, both physical and mental, is pivotal, especially since the health sector in Serbia is going through a crisis due to the aforementioned political, economic, and social changes following the process of transition in Serbian society.

It is within this broader context that I pose the following research questions, which I address and answer in detail in my thesis project:

1. What is the impact of Serbian culture on the gender identity of Serbian women?
2. How do women who have undergone hysterectomy perceive themselves after the surgery, and how does that perception influence their sense of self, gender identity, and sexuality?

3. How do women who have undergone hysterectomy communicate their gender identity to the people surrounding them, especially current and potential romantic partners?
4. How does communication with their relational partners improve or diminish their emotional status after hysterectomy?

1.3 Organization of the Thesis

Chapter I has presented an introduction and background information, as well as the objectives and scope of the study. It lists my research questions, and includes the personal story behind the research which introduces my family experiences as a reflection of Serbian culture. A brief introduction to all the subsequent chapters follows.

In Chapter II I provide the broader Serbian cultural context, which includes Serbian historical, social, and cultural climate, with special emphasis on the position and role of women in Serbia, as well as a short retrospective and analysis of Serbian myths of the “mother hero” and “self-sacrificing mother” and clarification of the importance of motherhood in Serbian culture. More specifically, the second chapter discusses the following issues: historical, political, and social circumstances; motherhood as an ideology; as well as cultural implications and motherhood discourse in Serbia. Furthermore, it addresses notions of masculinity and femininity, female and male sexuality, as well as the issue of domestic violence, in post-communist Serbia.

Chapter III is dedicated to the scholarly literature review for this study with an emphasis on research previously conducted on gender identity and partner communication in relation to hysterectomy procedure. Also, the methodology section is

included in this chapter, providing detailed information about recruitment and selection of participants in the qualitative study, development of the interview protocol, and an introduction to the theoretical background used in to analyze the data.

Chapter IV focuses on data analysis and discussion of findings, i.e. presentation of data gathered through in-depth interviews with informants in Serbia and discussion and implications of interview findings. In this chapter I will connect the interviews to the research questions posed above.

Finally, Chapter V contains the conclusions drawn from my work, a summary of the contributions my thesis has made, and a prospect of future research.

CHAPTER II

THE REPRESENTATION AND ROLE OF WOMEN IN SERBIAN CULTURE

We still live in a world in which a significant fraction of people, including women, believe that a woman belongs and wants to belong exclusively in the home.

Rosalyn Sussman Yalow (Co-winner of 1977 Nobel Prize for Physiology or Medicine)

2.1 Prologue

In late November of 1995, in one of my English literature classes at Faculty of Philology, Belgrade University, more than a hundred students, including myself, listened to our professor, one of the most distinguished Serbian female scholars, criticize her life as a woman. “We didn’t gain anything by ‘liberating’ ourselves. We just got more work, more duties, and more problems! Look at me: Right now I’m teaching this class which I had to prepare for beforehand, I will teach yet another one in two hours time and after that I will have my office hours for another two hours. And is that all? No, no, no! I still have to be home on time to prepare dinner for my husband and children who will be coming back hungry from work and school; I have to make the house look presentable; wash the dishes; iron clothes; do all the other female stuff. My mother and grandmother at least did not fool themselves that they could do it all—they only had to do the housework and that was it. No ‘liberation’ for them. But they were lucky—look what the ‘liberation’ has done to me!” my professor shared in a distressed voice. This accomplished woman was apparently not entirely happy with the life she leads as a professor of the prestigious Belgrade University, author of several books and numerous articles, a mother, and a wife. What was then in store for me, a freshman, living in

Serbia of the nineties, in the menacing shadow of the civil war, exposed to relentless nationalist indoctrination, disillusioned and confused, a woman horrified of being like her mother or grandmother, clueless about how to be anything else.

In retrospect, I realize that the stress expressed by my professor of having to undertake simultaneously so many female roles is a condition shared by my female professors in the U.S., and by contemporary women in developed countries around the world. However, the burdens faced by the women in Serbia are increased by an underlying belief that to be female is to bear children and that motherhood is not a personal, or even marital choice, but a patriotic obligation to the state. In this chapter I investigate and describe motherhood as an ideology in post-communist Serbia, which continues to manifest itself in the form of heroism and self-sacrifice, and discuss the situation of women in Serbia, a former socialist country undergoing transition, as well as the ways in which traditional and modern female roles collided in the period immediately following the fall of Communism and Socialism. In order to do so, I first briefly discuss historical, political, and social circumstances, and then provide definitions of ideology and motherhood. Next, I recapitulate the idea of motherhood as an ideology in post-communist and nationalist societies by identifying and elaborating on the myth of 'Heroic' and 'Self-sacrificial Motherhood,' thus providing a cultural context and supporting my claims by giving examples of several texts of popular Serbian culture, in an attempt to demystify the ways in which women and motherhood were and continue to be presented in the domestic and public arenas in Serbian society. Finally, I compare the notions of masculinity and femininity, discuss female and male sexuality,

and briefly refer to the problem of domestic violence in post-communist Serbia. In my concluding remarks, I refer back to my own study of hysterectomies and gender identity among Serbian women.

2.2 Historical, Political, and Social Circumstances

The latest issue of *Lisa*, one of the popular Serbian women's magazines, published in May 2007, in its rubric "People," features the story of Jasna Stanivuk, a successful Serbian businesswoman, a director of a thriving sales company, a loving wife, a passionate athlete, a humanitarian, and above all a mother. As the article states, "Jasna Stanivuk leads a successful firm, scuba dives, water-skis, but admits that her children are her whole world" (Jakob, 2007, p. 12). As a mother of four, an educated, attractive, successful woman, a devoted wife and daughter, and an excellent cook, Jasna Stanivuk epitomizes the ideal Serbian woman—who "puts motherhood in the first place. Always!" (Jakob, 2007, p. 12). Even when it means going to bed after midnight every night and getting up at 6 a.m. every morning to be with her children.

This article is in no way unique—it is only a single one in a long series of similar stories, featuring famous Serbian businesswomen, singers, actresses, as well as female artists, authors, academicians, politicians, athletes, etc. What all these articles have in common is open, even compulsory, glorification of the self-sacrificing mothers in Serbia who often feel the need to apologize for being successful in their jobs by stating that they are, above all else, mothers whose children (not their own needs and desires) always come first. Whenever an article features a successful young single woman, she is typically quoted saying that in spite of the fulfillment provided by her career, she cannot

wait to become a mother and fulfill her 'natural' role. The reason for this general attitude towards motherhood as an imperative in Serbian society lies principally in historical, political, and social circumstances.

Serbia is located in the central part of the Balkan Peninsula and at the crossroads between Central, Southern and Eastern Europe and the Middle East. The river Danube, the longest river in the European Union and Europe's second longest river after Volga, which has been an important international waterway for centuries and remains one today, flows through the northern third of Serbia. Due to its specific geo-strategic position Serbia has always been in the very focus of transport and traffic routes connecting various parts of Europe and the Middle East. Due to all these factors, many armies wished to conquer it and numerous wars were fought on its soil. In addition to that, Serbia took part in many wars waging across Europe, including the Balkan Wars, World War I, and World War II. Roughly speaking, in the period between 1202 and 1999, Serbia participated or was affected by as many as fifty major wars and numerous armed conflicts (Singleton, 1999).

After the fall of the Berlin Wall in 1989, the level of violence and turbulence accompanying the social and political makeover of countries in Eastern and central Europe rapidly increased, becoming a severe problem. Following the long and painful death of Communism in the multiethnic republics of former Yugoslavia, confusion and turmoil reached their peak in the 1990s. Post-communist reality in Yugoslavia was that of a highly charged national, cultural, and gender politics. The reconstruction of power in Yugoslavia greatly affected all social structures, especially the gender order,

reinforcing the ancient dominance of patriarchal principles temporarily subdued by the pseudo- equality enforced by Tito's communist regime. Even in those newly born post-communist countries with a relatively ethnically homogenous population structure (such as today's Serbia), formerly recognized rights of women, especially the right to abortion, were no longer viewed as 'given.' What took place in these fresh, new societies, just galvanized into life, was a form of re-colonization of female bodies in the name of a revived doctrine of the ancestors—patriarchy. In spite of the numerous negative aspects of the communist and socialist regimes, Socialist Yugoslavia upheld an official policy of gender equality based on a Marxist ideology, which guaranteed women's rights to vote, to employment, to political office, and to education. As Bracewell (1996) argues, "After the war, the image of emancipated woman functioned as a symbol of Yugoslav modernity and socialism, and the ideological commitment to women's equality was expressed in legislation" (p.25). After the fall of communism in most countries of Eastern Europe, including Yugoslavia, many of the communist ideals, including gender equality, were completely rejected and discredited. The response in many cases was "a complete reversal, a return to the 'traditional values' of patriarchal society, in which women's role lies primarily in the private sphere of domesticity and motherhood" (Bracewell, 1996, p. 25). As Shiffman, Skrabalo, and Subotic argue, the nationalist policy in Serbia in particular aimed to "reassert 'natural' gender roles, reaffirm the traditional patriarchal family, and regenerate the nation by emphasizing patriotic motherhood and subordinating women's autonomy to the demands of the national collective" (2002, p. 628). The concept of patriotic motherhood defines women's

primary civic obligation as the “production of loyal sons capable of defending the nation against its internal and external enemies” (Kennedy, 1999, p.109). In other words, the ideology of patriotic motherhood defines women as reproducers of children to support and strengthen the nation, and especially reproducers of sons who will fight for the nation. For that reason, one of the most important forms of control over women was reproductive one, which helped construct and maintain a new form of ‘male democracy’ for the people freshly out of the communist darkness. The main component of patriarchal democracy that ruled in Serbia of the 1980s and the 1990s was the motherhood discourse.

After the Second World War, when the former Yugoslavia entered the era of communism, women were, similarly to those living in most of the Eastern European countries at the time, faced with a paradox, a “‘double burden’ of employment and domestic work, their position in practice often being less favorable than that of many women in the period between the wars” (Hawkesworth, 2000, p. 10). As Nikolic-Ristanovic (2002) states, “it seems that the role of woman as mother as well as self-sacrifice of woman for collective aims is central to the ideology of both communism and post-communism. [...] It is also central to the nationalism and war discourse in Serbia, as well as in other parts of the former Yugoslavia” (p. 55). Marginalization of women and their almost complete absence from post-communist Serbia’s political scene also exposed the detrimental effects of the communist-patriarchal heritage, which provided women with the right to education, divorce, work, equal pay, and abortion, but failed to provide them with the ability to become active political figures and affect their own

political fate. In post-communist Serbia, as well as in other countries of the Eastern block, identities of women, their role in society, as well as their symbolic representations were brutally re-traditionalized in an attempt to feed the newly found nationalist and sometimes even xenophobic feelings, greatly supported by the patriarchal power figures, such as, in the case of Serbia, despotic neo-socialist Slobodan Milosevic. These extreme feelings resulted in the process of mythologizing, as well as subjugating and instrumentalizing women, who were sometimes viewed as the sacred bearers of Serbian sons and sometimes simply as ‘child-bearing-machines’ in an everlasting construction of female otherness. The true nature of gender relations in Serbia of the 1980s and 1990s and the place of women in this universal state of disempowerment lies in the escalation of gender dichotomy, i.e. emphasizing the ‘fundamental’ differences between males and females, and the newly reconstructed patriarchy, i.e. the (re)construction of the ‘natural’ female role of breeders for the sake of the Serbian nation, and the ideology of womanliness in Serbia. Mothers were and continue to be perceived as the symbols of the nation, responsible for its biological and cultural survival. Evidently, the tremendous social, political, and economic crisis in Serbia had, as a consequence, the deterioration of women’s social position. However, this was not the first time that Serbian women were deemed the “mothers of the nation” (Bracewell, 1996, p. 25). The idea of heroic or self-sacrificial motherhood was the one that had existed in the Serbian culture for centuries.

2.3 Cultural Implications: Motherhood Myths and Motherhood Discourse in Serbia

Woman’s biological role of reproduction and motherhood has, undoubtedly, been of critical significance for carrying out the state national project of many national

groups. In other words, nationalist ideology and practice more often than not involves state interference in biological reproduction in an attempt to reproduce members of their own national group and increase its size, while, at the same time, trying to stop the other, enemy group from reproducing. As a result, women themselves were and still are often regarded as instruments of reproduction in an attempt to numerically increase the nation. In many parts of the world, the ideology of motherhood, based on a range of different myths of motherhood and socially constructed as a vital aspect of femininity, has set standards for women to measure themselves against, as well as for others to measure women against.

2.3.1 Ideology

The concept of ideology is central to sociological inquiry and it represents “the conceptual system by which a group makes sense and thinks about the world” (Glenn, Chang, & Forcey, 1994, p. 9). Ideology is a term constructed in the Marxist tradition to talk about how cultures are structured in the ways that allow the group in power to have the highest level of control with the minimal amount of conflict. Karl Marx is considered to have revived the term ideology, originally coined by Destutt de Tracy, who referred to ideology as the “science of ideas.” However, there is no single Marxist definition of ideology, since Marx raises views on ideology throughout his writing. One of Marx’s most straightforward statements about ideology appears in *The German Ideology*, which he wrote with Frederick Engels. According to their definition, ideology itself stands for the “production of ideas, of conceptions, of consciousness,” everything that “men say, imagine, conceive,” and it includes such issues as “politics, laws, morality, religion,

metaphysics, etc.” (Marx & Engels, 2001, p. 47). The “ruling ideas” of a given era are, however, those of the ruling class: “The ruling ideas are nothing more than the ideal expression of the dominant material relationships, the dominant material relationships grasped as ideas; hence of the relationships which make the one class the ruling one, therefore, the ideas of their dominance”(Marx & Engels, 2001, p. 64).

On the other hand, Michel Foucault, renowned French post-structural philosopher, takes a radical departure from Marxist views on ideology by critiquing the production of ‘truth’ and refusing to link ideology with any rigid, settled notion of truth. For Foucault, the truth is fashioned and refashioned by the supporters of an ideology. In effect, Foucault eventually exchanged the term ‘ideology’ for his preferred term, ‘discourse:’

Each society has its regime of truth, its 'general politics' of truth: that is, the types of *discourse* which it accepts and makes function as true; the mechanisms and instances which enable one to distinguish true and false statements, the means by which each is sanctioned; the techniques and procedures accorded value in the acquisition of truth; the status of those who are charged with saying what counts as true. (1980, p. 131)

Conversely, Louis Althusser, a structural Marxist and a philosopher, builds on the work of Jacques Lacan to identify the way ideology functions in society. He moves away from the earlier Marxist understanding of ideology, and for him, “Ideology represents the imaginary relationship of individuals to their real conditions of existence,” which shapes us as persons, “hails us,” and calls us into being (Althusser, 2001, p. 109).

For the purpose of this chapter, I will use Althusser's notion of ideology to demonstrate how the governing institutions in Serbian society work through values and systems of symbols in order to legitimize the existing order through the prevalent philosophy about the way things are and how the society should work. These ideas (often rooted in symbols and cultural practices) orient people's thinking in such a manner that they accept the current way of doing things, the existing sense of what is 'natural,' and the current understanding of their roles in society. This socialization process is carried out, according to Althusser, by the state ideological apparatuses—by religious leaders, politicians, the schools, the family, and through cultural forms (such as literature, motion pictures, newspaper articles, etc.). I use this model of ideology to explicate the ways in which the idea of motherhood as heroism and self-sacrifice is and continues to be referred to in public political discourse in Serbia.

2.3.2 Motherhood

The term 'motherhood,' as Dally (1982) reports, emerged as a concept in Victorian times "when it was reified as being motherliness, of mothering" (as cited in Phoenix, Woollett, & Lloyd, 1991, p. 6). In the world of today, motherhood is usually seen as "an essential task or stage of women's development as well as a crucial part of their identity, often from childhood" (Phoenix, Woollett, & Lloyd, 1991, p. 6). Since motherhood in many ways constructs a woman's identity regardless of her culture, social status, class, race, or ethnicity, "being a mother is considered a woman's major social role. Society defines all women as mothers or potential mothers. Motherhood is compulsory for women: most little girls expect to become mothers, and women who do

not are considered deviant” (Roberts, 1997, p. 10). Motherhood (or mothering) can be defined as a culturally and historically variable relationship, “in which one individual nurtures and cares for another” (Jaggar, 1983, p. 256), and the ways in which motherhood and the role of women as mothers are understood greatly depend on the historical and ideological circumstances in which ideas related to motherhood develop. Hondagneu-Sotelo and Avila argue that that motherhood “is not biologically predetermined in any fixed way but is historically and socially constructed” (1997, p. 549). Numerous other authors also refer to motherhood as a social and historical construction (Bassin, Honey, & Kaplan, 1994; Glenn, 1994; Risman, 1998). By depicting motherhood as natural, “a patriarchal ideology of mothering locks women into biological reproduction, and denies them identities and selfhood outside mothering” (Glenn, Chang & Forcey, 1994, p. 9). Despite the cultural climate or geographical location, motherhood as a concept is greatly idealized and romanticized as the supreme emotional and physical achievement in a life of every woman (Ussher, 1990). However, regardless of the global importance assigned to motherhood, different cultures may have different understanding of the nature of motherhood and women’s role as mothers.

As Yuval-Davis and Anthias (1989) assert, “women participate in the ideological reproduction of the state collectivity and are transmitters of its culture” and more often than not this participation involves a certain amount of governmental interference in women’s lives (as cited in Phoenix, Woollett, & Lloyd, 1991, p. 17). The levels of intervention differ from country to country and may take the form of population control or violation of women’s reproductive rights. For that reason, women’s bodies need to be

protected not only from “those states seeking to use their reproductive capacities for *developmentalist*-oriented fertility *control*, but also against those wanting their bodies for *nationalistic*-oriented fertility *promotion*” (Shiffman, Skrabalo, & Subotic, 2002, p. 627-8; emphasis in the original). In other words, women’s bodies and their reproductive ability should be sheltered not only from the state’s desiring to control them through family planning programs which limit a number of children per family, but also from state programs deliberately seeking to increase the fertility level in order to promote and strengthen national power. In post-communist Serbia, the government has been deliberately seeking to increase rather than decrease fertility level by using mothers as living and breathing symbols of the nation, “by emphasizing women’s responsibility for the biological and cultural reproduction of the nation” (Bracewell, 1996, p. 25), and by deliberately presenting motherhood as heroic and self-sacrificing in the public discourse. However, using an idealized imagery of motherhood as a tool for promoting a nationalist agenda is by no means unique to post-communist Serbia. Some of the examples of similar political actions can be found in nineteenth-century France (Offen, 1984) and Vichy France (1940-1994) (Pollard, 1998); in fascist Italy under Mussolini’s dictatorship (1922-1945), where “the duty of women toward the nation lay first and foremost in making babies” (De Grazia, 1992, p. 41); in Nazi Germany (Koonz, 1984; Rupp, 1977), where “the ideal Nazi woman would serve her people and her country, making whatever sacrifices were demanded of her” and whose “first and foremost duty was, not surprisingly, to be a mother” (Rupp, 1977, p. 379; p. 370); or the post-communist politics of other contemporary East European countries (Funk & Mueller, 1993).

Furthermore, we can conclude that it is virtually impossible to separate a nation's reproductive rights politics from its historical and sociopolitical context. As Armstrong (2003) argues,

Historically, at moments of revolution in gender relations and roles, reproduction has become a tool to manipulate women—by defining them solely in terms of their reproductive function, by accusing them of failing society because they are producing too few children or children of inferior quality. At these moments, women are explicitly expected to bear responsibility for the social order, as well as for offspring. (p. 20).

This was precisely the case in post-communist Serbia, in which the 'ideology of motherhood' has encouraged women to be heroic and self-sacrificing mothers, now and again praising them and every so often critiquing them severely, simultaneously justifying their homebound existence and keeping them outside of the centers of real power.

The building blocks of all ideologies are myths. Barthes (1972) defined a myth as an uncontested and unconscious assumption that has been so widely accepted that its historical and cultural origins have been forgotten. As such, myths of motherhood are often publicly presented as "natural," "instinctual," and "intuitive" as opposed to "cultural," "economic," "political," and "historical" (Hrdy, 2000). Ideologies, including the ideology of motherhood, are born when myths are combined into consistent philosophies and politically sanctioned by the culture.

2.3.3 Beliefs, Rituals, and Myths related to Motherhood in Serbia

Mothers in the Balkans, especially in Serbia, have typically been surrounded by a semi-sacred aura, which provides otherwise oppressed and undermined females with a plane on which to exercise some sort of power. Even in contemporary urban settings, where the majority of women work outside the home, mothers and wives “continue to manage the family arena, setting and maintaining the moral tone of the home while, at the same time, exerting a certain influence on their sons even outside the context of family life” (Simic, 1999, p. 27). By accepting these mythic constructions from the past, modern women reinforce the cultural norms, thereby perpetuating them and keeping them unchallenged (Butler, 1990). Nowadays, with all the inevitable sociopolitical changes, the conflict in Serbian women occurs as a result of the discrepancy between the motherhood myth and the actual reality and results in the cultural representation of ‘superwomanhood’—women are required to be able to cope with numerous competing (and often conflicting) demands (Ussher et al., 2000), and always remain in service to someone or something, in the undying spirit of the favorite slogan of Socialist Yugoslavia: “Woman as a housewife, a lover, and a worker” (Andjelkovic, 1998, p. 236). Even though the situation of Serbian women is not entirely unique, as it is shared by other contemporary women in the world, it is further complicated by many beliefs, and rituals, and myths, which emphasize motherhood as a heroic, self-sacrificing, and patriotic obligation of each woman to the nation and state.

2.3.3.1 Beliefs and Rituals

A very significant factor in defining motherhood in Serbia is the predominant Orthodox Christian faith and the influence of the Serbian Orthodox Church, which in many ways corresponds to the postulates of traditional culture, namely patriarchal and family/relative principles, all of which have for their basis the model of the self-sacrificing mother. The story of Mary, the Mother of Jesus, which serves to express the Christian idea of an ideal mother, has its social, historical, and psychological importance in Serbian culture as well and represents an ultimate example of model womanly and motherly behavior, which provides the salvation and conservation of national identity. In Serbian culture, motherhood is an institution of permanent sacrifice for the collective good, which, according to a much-popularized line from a Serbian epic poem, prompts the mother to “Feed the son and send him to the army.”

As Tripkovic (1995) states, “Maternity and giving birth are in [Serbian] culture a very important collective act which is accompanied by a great number of beliefs, magic activities, and rituals. A characteristic of this culture is that the normative encouragement to giving birth which glorifies the mother, is confronted with the patriarchal male principle of order, with the woman and mother as its victims” (p. 122). According to the traditional culture of the Serbs, a woman is required to fulfill the roles of daughter, sister, wife/lover, and most importantly, mother. To become a mother means to reach the highest and impervious status in the traditional culture. Even if she is denied her rights when it comes to her other roles, in the role of a mother a Serbian woman is, at least normatively, the most respected (Tripkovic, 1995). When she

becomes a mother, the woman reaches the optimum status in her traditional community, and first of all, she manages to preserve her marriage. That is to say, only with giving birth to her own children, especially sons, a woman insures permanence of her marriage, which for her, more than for her husband, means security. Children are the only goal and legitimization of a marriage in a community in which it is considered the greatest curse of all not to have offspring. In case that the marriage is unfruitful, a woman is typically blamed and the marriage falls apart, with or without her consent. In some parts of Serbia it is even believed that a woman who is unable to preserve her offspring, i.e. perform her main function as a woman by giving birth and bringing up healthy children, is in fact a witch. (Tripkovic, 1995).

Beliefs and rituals in Serbian culture, as well as traditional folk creative works (especially epic poetry), are a part of a system of values which contain both the elements from pre-Christian, Pagan times, as well as the elements from the more recent Christian past. Pregnancy is the only time in a woman's life when she is free to express her own desires and the people from her immediate family are obliged to fulfill her wishes, until the baby is born. Furthermore, the greatest number of rituals and beliefs in Serbia is related to providing offspring. The purpose of the marriage is bringing children into the world and giving birth is completely contextualized by the traditional culture, and patriarchal family and marital relations. In such a culture, a woman is considered to be the culprit for infertility or sterility problems and she is the one who is supposed to 'provide fertility' in her marriage. If she does not manage to achieve fertility, she will find herself in a very unfavorable position. A 'barren,' sterile, or infertile woman is

hated and resented by those in her social surroundings². There are a number of negative, defamatory, and derogatory words and expressions for such a woman in Serbian language.³ (Tripkovic, 1995).

If a Serbian woman does not have children for any reason, she is forced to desperately try to conceive because she is met with direct or indirect disapproval and condemnation of her community. Furthermore, “under such circumstances she herself perceives pregnancy as an essential need which she places before her desire to live and her personal safety and happiness” (Tripkovic, 1995, p. 129). For that reason a woman who wishes to conceive, a pregnant woman, or a woman about to give birth is the main, and often the only, performer of the various fertility rituals. The only witness of her effort is also a woman—her mother-in-law, a female relative, a female neighbor, or a female witchdoctor. As Tripkovic states, “a woman who wishes to conceive is often aided by a pregnant woman, which demonstrates a specific gender-group solidarity [in Serbian culture]” (1995, p. 130).

Fertility rituals in Serbia, as in other cultures, are typically performed during the marriage ceremony, to ensure the fruitfulness of the union. The most typical ritual is throwing wheat at the bride while she enters her new home. In some parts of Serbia the new bride bakes her own wedding cake or sits in her mother-in-law’s lap to make certain

² Through out this report I make an effort to distinguish between ‘infertility,’ the condition of reproductive impairment, which may be treated and resolved and ‘sterility,’ the complete absence of reproductive capacity, which is the outcome of a hysterectomy (both definitions provided by the American Society of Reproductive Medicine).

³ Djordjevic lists the following derogatory words for childless women, which cannot be precisely and adequately be translated into English, since such a great variety of terms denoting a childless woman does not exist in English language: nerotkinja, nerotka, nerodusa, nerodnica, bezdetka, bezdetkinja, stirkinja, stirka, jalovica (as cited in Tripkovic, 1995, p. 129).

she has children in marriage. These forms of magic are relatively mild and do not require a special effort to perform. However, if it turns out that the marriage is barren, the ‘remedies’ prescribed are more complex and require more discipline from the woman. For example, some of the rituals require the woman to eat bugs, ants, worms, or barley found in horse droppings, or drink various unusual potions made with herbs, and, in some cases, even fresh rabbit blood. Some women persistently visit Orthodox churches of monasteries, drink water from the springs known for their healing powers, or say prayers in isolation. If a woman cannot have a child through healing practices and magical rituals, she is still required to demonstrate her persistence and her great desire to have a child (Tripkovic, 1995, Djordjevic, 1990). All the aforementioned rituals and magical practices have their foundation in and spring out from the mythical representations of motherhood in Serbian culture, and many of them are evident in various products of popular culture.

2.3.3.2 Myths

As Rushing (1989) argues, myths being stories that are told and retold, “myths are consciously shaped by their communities” (p. 2). As Rushing (1989) further explains, “the cultural expression of a myth responds to historical and political contingencies, and may appropriate archetypal imagery, consciously or unconsciously, for rhetorical means—that is, to further the ends of a particular person or group of people, or to advise a general course of action” (p. 2). The most relevant archetype for creation of the Serbian myths of ‘Mother Hero’ and ‘Self-sacrificing Mother’ is the Jungian archetype of the Great Mother or Great Goddess. The archetypal figure of

mother often stimulates an instinctive reaction in us; each of us has his or her own individual experience of mother, in addition to the mythic and collective one. As Joseph Campbell argues, “There have been systems of religion where the other is the prime parent, the source. Mother is really a more immediate parent than the father, because one is born from the mother, and the first experience of any infant is the mother” (1988, p. 165). Furthermore, “the act of generating a child is a cosmic act and is to be understood as holy” (Campbell, 1988, p. 169). According to Carl Jung (1968), there are two prototypically opposing aspects of mother: the “Good Mother” and the “Terrible Mother,” both of which represent principal features of the Mother Goddess mythology. Jung further describes these two aspects of the archetypal mother, view the positive one as “all that is benign, all that cherishes and sustains, furthers growth and fertility,” while its negative counterpart “connotes what devours, seduces, and poisons” (82). Jung’s follower, Erich Neumann, comprehensively expanded Jung’s ideas of the archetypal mother and declared that this particular archetype mirrors a bipolar “elementary character,” whose “negative pole is the Terrible Mother [...] and whose positive pole is the Good Mother.” Moreover, Neumann argues that, “bearing and releasing belong to the positive side of the elementary character” and “in so far as the Feminine releases what is contained in it to life and light, it is the Great and Good Mother of all life.” On the other hand, he claims that, “the Great Mother in her function of fixation and not releasing what aspires toward independence and freedom” takes over the qualities of the Terrible Mother (1974, pp. 64-65). The Great Mother archetype was reflected in everyday life in the creating of the ‘good woman,’ the image much used in Serbian

cultural imagery. As Whitmont states in his book *Return of the Goddess* (1997), “in order to be suitable and limited to continuing a patriarchal family lineage a ‘good’ woman had to be a ‘good breeder’ and limit the ‘use’ of her body to her lord whose property she was to be” (as cited in Rushing, 1989, p. 5).

In the Serbian motion picture *Petria's Wreath* (in the original, *Petrijin Venac*), a social drama filmed in 1980, the motherhood discourse and the impact it has on Serbian women, their identity, and their sense of self is very successfully depicted. The story of the movie takes place in a small mining village in Serbia and covers the periods before, during, and after the Second World War. It is a story of a tragic life of an illiterate peasant-woman and her relationships with three men she loved.

Petria's Wreath tells a story of a Serbian woman and her life of nearly agonizing hardship. In the opening scene of the film, the main protagonist, Petria, is shown as an old peasant-woman living in a small house in a village with only several cats to keep her company. It is apparent that she has no children of her own and lives alone but, nevertheless, regards life and her own destiny in a positive, even jovial manner, observing that after the third glass of Serbian brandy, things somehow always seem to be better. This state of innocent cheerfulness is, as the viewer is later able to observe, about as happy as Petria ever gets to be during the course of the story. The film moves chronologically through the variety of tragedies of Petria's life, which include an ill-fated first marriage, the loss of two children (first a son and then a daughter) and the inability to bear others, banishment by the first husband for being infertile, and entering yet another, not much happier marriage. Through all the disease, misfortune, and death that

torment and plague Petria's loved ones and herself, she preserves a quiet determination to continue with her life and accept her lot, although she becomes justifiably superstitious at times. At the burial of her second child, in spite of the clearly Christian service which is in session, Petria, as a true crypto-Pagan, forces a live chicken into the grave as a sacrifice to the gods of the Underworld, hoping it will save her future children from death and spare her husband and herself any further sorrow. Unfortunately, the sacrifice seems not to be accepted by the mystic chthonic⁴ deities to whom it is offered, and Petria's husband asks her to leave right after the funeral of their daughter, telling her that, "There must be something wrong with you when things are like this." He continues to blame her for their misfortune by saying: "You bring bad luck with you." Finally, he informs her that, "In a peasant's house one needs a woman who will bear children, bear sons, who will preserve children from death." Petria accepts these direct accusations without complaint. She herself believes she is the one to blame. Later in the movie, when asked by the owner of the tavern in which she is to start working as a waitress why her husband drove her away, she replies with conviction, shame, and acceptance: "He wants a woman he can have children with." As long as she is unable to give birth to sons to replenish those lost in the War and does not provide her husband with an heir, Petria considers herself rightfully ostracized for not fulfilling her 'natural' role.

One of the most compelling scenes in the movie is the scene of the birth of Petria's first child. Petria has a constant conflict with her mother-in-law, who does not view her as an acceptable wife for her beloved son, because of her humble origin. She

⁴ Of the underworld

constantly spies on Petria and her husband, even during their first wedding night.

Petria's husband shows great reverence for his mother and at one point even brutally beats Petria and orders her to leave for offending and, allegedly, plotting against her mother-in-law by going to see the local medicine-woman (referred to as *the witch* in the movie). However, after Petria informs her husband that she is with a child, presumably carrying a son, he immediately embraces her, completely forgetting the revolting scene of violence that took place between them minutes before that. At the news that Petria is pregnant, her mother-in-law immediately withdraws into the shadows behind the barn. The new life, the son Petria is carrying inside her, gives her a new sort of power, which may ultimately make her more influential than the omnipotent mother-in-law herself.

According to a research study conducted in Serbian villages in 1988, the power of older women is evident in many Serbian villages, where “adult male informants, some of the advanced age, casually relate that, while they frequently make important decisions without consulting their wives, they almost always seek the opinions of their mothers” (Simic, 1999, p. 13). Similar behavior to the one depicted in the movie *Petria's Wreath* is evident in another Serbian feature film from 1976, *The Feather Gatherers* (in the original, *Skupljaci perja*). The Gypsy protagonist, who shows no remorse for repeatedly beating his wife in public and spending all the money on drink while smashing glasses on the tables in a tavern “in a demonstration of machistic prowess” is also shown as a respectful, loving son, “meekly acquiescing to his mother's demands and seeking her advice in both business and love” (Simic, 1999, p. 13).

In one of the scenes of *Petria's Wreath*, Petria, whose due date is evidently approaching (as clearly indicated by her enormous belly and slower movements), is working in the field together with her mother-in-law and husband. While picking corn, she realizes that she is about to have a baby and informs her mother-in-law about it, who replies: "Go, you're useless here anyway." According to the custom, Petria is supposed to give birth in secrecy, hidden from the eyes of the world. She is also required to wait for her mother-in-law to come and cut the umbilical cord after the child is born, which is an extremely important part of the Serbian folk tradition. Being inexperienced, Petria is very frightened about the whole process of giving birth to her first child and she implores her mother-in-law to come with her and help her. The mother-in-law declines, claiming she needs to finish her work, but assures Petria that she will be with her shortly. However, the mother-in-law purposefully does not come to Petria's aid until hours later, when her husband finds her unconscious and bleeding in the barn, with her infant son lying on the floor beside her and the umbilical cord still uncut. The husband is the first to realize that the child is dead and breaks the news to Petria, who, although completely inexperienced in the matters of birth, fully comprehends that her mother-in-law purposefully decided not to come earlier and help her. Petria is aware of the fact that her mother-in-law is to be blamed for the death of her child. She starts to shake and cry in despair, while her mother-in-law, with no emotion in her voice, says to her: "Stop crying. This is what God wanted." As a response, Petria screams at her in a wild paroxysm of horror and sorrow: "This is not what God wanted, this is what you wanted!" From this scene, it is clear that in Serbian society "women achieve power and

authority not by virtue of being wives but as the result of becoming mothers [...]. In this way, [...] women legitimate their status within their husbands' kinship groups by giving birth to sons and through the influence they exert over their children in general (Simic, 1999, p. 14). As shown in *Petria's Wreath*, the wife initially enters her husband's house as an outsider, "and during the first years of marriage she is, in effect, *unprotected* by children of her own who, upon their birth, will be full members of their father's lineage" (Simic, 1999, p. 18). Furthermore, the real threat to a woman's position in the family comes not so much from her husband, as from her mother-in-law, "against whom a daughter-in-law's principal weapon is the status and pride which results from grandparenthood," especially in the case of male grandchildren (Simic, 1999, p. 22). Hence, Petria's mother-in-law prevents her from ultimately acquiring the supremacy over the household by not allowing her to bring a son to this world, as this may jeopardize her status as the power behind the throne. Without the son, the daughter-in-law remains unprotected from her mother-in-law, since "the son as a member of his father's lineage and the inheritor of a share of his father's property provides the validation of his mother's position in what is after marriage initially, for her, a 'household of strangers'" (Simic, 1999, p. 22). Since sons occupy positions of authority and prestige in the patriarchal society, mothers gradually accrue their power through the medium of their sons.

A Serbian mother is also seen as a self-sacrificing mother, who "surrounds herself with an aura of martyrdom and virginal purity, giving visible expression of the 'pain' associated with sexuality and childbirth" (Simic, 1999, p. 24). This semi-sacred

aura surrounding mothers in the Balkans and Serbia is probably of very ancient character (Simic, 1999). The theme of the martyred and self-sacrificing mother is certainly not a new one in the South Slav epic poetry. Nicolò Tommaseo, XIX century Italian analyst of the Slavic patriarchal world and Serbian folk poetry writes: “In Serbian folk poems mother’s name is truly sacred: She is like a pillar that raises men’s love and respect towards heaven” (Tomasseo, 1982, p. 228).

The Building of Skadar is one of the most beautiful of Serbian epic poems, recorded by the great Serbian language reformist and ethnologist Vuk Karadzic in 1815.⁵ The story of the poem takes place at a fortress, the city of Skadar, which King Vukasin is building with his two brothers. The fortress is being built during the day by masons, while the construction is undone at night by natural spirits (fairies). In a strange, prophetic dream, one of the brothers hears a voice from heaven telling him to immure the first woman to visit the work site and build her into the walls of the fortress as a sacrifice. As it happens, his own wife, bearing flowers, food and wine for the masons, is the first to arrive. To appease the spirits, husband decides to entomb his own wife into the city walls, leaving behind an infant in the cradle. However, as a response to the woman’s cries and pleas to save her child (she is apparently completely oblivious to her own tragic destiny), “openings are made in the masonry so that her breasts are left free to nourish her small son, and even after she dies, the milk continues to flow until the child has grown up. Later, a spring of “miraculous and healing water” appears at the site”

⁵ The poem has been finely translated by Sir John Bowring, in *Servian Popular Poetry* (1827), and the translation has been reprinted in Petrovic’s book *Hero tales and legends of the Serbians* (1914, pp. 198 sqq.).

(Simic, 1999, p. 26). Even if a woman is obliterated due to the respect for unwritten rules of the culture, she is sacrificed only as a woman, but as a mother she is pardoned and celebrated by all.

Due to numerous wars fought on Serbian soil and many wars and battles Serbia participated in, the cult of heroic motherhood flourished in Serbia in which mothers were required to bear as many sons as possible to send them off to the army, and at the same time be brave and strong enough to see them die in battle. One of the main reasons for the salience of the cult of heroic motherhood in Serbian culture lies in the five-hundred-years-long Ottoman rule. In order to constantly replenish its powerful army by providing new soldiers, the Ottomans took children from families in the conquered lands, including Serbia, trained them, and converted them to Islam. These soldiers called Yanicar were the Ottoman's empire most feared warriors, and many of them became some of the highest ranking Ottoman military leaders, such as Serbian born Mehmet Pasha Sokolovic who became the Grand Vizier of Sultan Suleyman the Magnificent (Singleton 1999). Serbs greatly resented this practice and in many cases would hide their male children in forests, teach them to pretend they were retarded or to walk with a limp, and would sometimes even mutilate themselves by cutting off one of their fingers to save them from becoming Yanicar and later terrorizing their own kin.⁶

The event which officially marked the beginning of the Ottoman rule in Serbia, even though the Ottomans did not completely conquer Serbia until 1459, was the Battle

⁶ All this was masterfully described in the historical novel "The Bridge on the Drina" written by Ivo Andric, the winner of the 1961 Nobel prize for literature. The novel was first published in Serbo-Croatian language in 1945 and was later translated into many languages.

of Kosovo Polje—the great battle between the Serbs, whose medieval state was located there and the Ottomans, who were penetrating the Balkan Peninsula. The battle, which was allegedly extremely brutal, took place on June 28, 1389 (15 June according to the Gregorian calendar) and both Turkish Sultan Murat I and Serbian Duke Lazar Hrebeljanovic perished in it, as did many soldiers on both Serbian and Ottoman side (Trgovcevic, 1999). As Trgovcevic (1999) states, “[The Battle of Kosovo] had significant consequences for incomparably weaker Serbia, because the loss of an entire generation and economic collapse marked the decline of the Serbian state, its gradual crumbling, fragmentation and ultimate breakdown” and it provided the foundation for the Serbian national myth of Kosovo. According to tradition, especially oral tradition and folk poetry, as well as historical data, the medieval Serbian empire was instantaneously defeated by the Ottomans, and the flower of Serbian nobility perished on the ‘Field of Blackbirds.’ The battle subsequently became the focus of a wide range of epics, many of which are more based on mythological archetypes than on verifiable history. The myth of Kosovo was later frequently evoked in Serbian history and oral tradition, especially in the times of great strife and war. Particularly glorified were Serbian women who remained to bury the dead and rebuild the state from the ashes by bearing sons who were to become new soldiers, as well as self-sacrificing and heroic mothers who gave up their sons for the sake of Serbian state.

One of the finest ballads about the battle on the Kosovo Polje, *The Death of Mother of the Jugovic*, masterfully illustrates the image of Serbian self-sacrificing and heroic mother. Mother of the Jugovic, who is not even referred to by first name in the

poem but is only identified through her role as a mother, is a long-suffering mother of nine sons who offers her children to die in the defense of the fatherland against the Ottomans at Kosovo Polje, without shedding a tear after learning of their death and the death of her husband. At the end of the poem, after two black ravens drop a hand of her son Damjan into her lap (her daughter-in-law recognizes the hand for her husband's by his golden wedding ring), mother's heart breaks with sorrow and she dies as well. Even though it originated in XIV century, *The Death of Mother of the Jugovic* is still taught to children age 11 and 12 in schools all over Serbia, and they are required to either memorize the poem in its entirety or learn parts of it by heart and recite it in front of the entire class. Very often, depending on each individual teacher's requirements, schoolchildren are also required to write an essay analyzing the poem for a grade. I still know the entire poem by heart and remember that both my classmates I were greatly affected by its powerful imagery. In addition, there are frequent references to in Serbian popular culture and media, and it is still, even though many centuries passed since the Battle of Kosovo, very much present in everyday life.

As a modern response to the cult of Mother Jugovic, Serbian Orthodox Church has been awarding the "Mother of the Jugovic" medals to Serbian mothers for having four or more children since June 1993. In 1993 they awarded sixteen gold and fourteen silver medals. Unsatisfied with the performance, the representatives of Serbian Orthodox Church admonished with regret, "In earlier times, mothers were able to send as many as nine sons to the emperor's army, so that they could fight for the freedom of the country

and of their Orthodox faith. We have such mothers today, too, but very few” (as cited in Zajovic, 1995).

On July 2, 2005, the daily newspaper *Glas Javnosti* reported that one of the bishops of Serbian Orthodox Church, Artemije, awarded a hundred Serbian mothers from Kosovo with four and more children with silver and golden medals of the “Mother of the Jugovic,” while each newborn was awarded a hundred euros from the governmental fund for Kosovo (Stodic, 2005). The article quotes the awarded mothers saying that Kosovo cannot be defended by words but by giving birth to offspring, because that’s the only way to survive as a nation.

An even more recent article published by the daily newspaper *Politika* on June 20, 2007, provides the story of Ljiljana Stanojkovic from the village of Susici in the municipality of Strpce in Kosovo, who is a mother of eleven. When she gave birth to her sixth child she was awarded the “Mother of the Jugovic” medal. Even though the article reports on the nobility of such attitude towards motherhood, it also suggests that the Ljiljana and her husband Radovan are experiencing serious financial difficulties and provides a bank account for concerned readers of *Politika* to give their financial contribution to help the family. When asked whether they are planning to have more children, Ljiljana and Radovan say in unison that they have already helped Serbian birth rate in Kosovo enough, similar to other families living there who have four or five children each. “It’s time for women from Belgrade to give birth,” they are quoted saying in the article. One of the readers of *Politika* posted an online comment in response to this

article saying: “Way to go, heroes! These are real heroes, heroes of life! It would be better if they were given what’s necessary to make a living [...] than medals.”

As the daily newspaper *Danas* reported on December 29, 2006, workers of factory *Metalac* from the Serbian city of Gornji Milanovac who had a baby during the year 2006 were awarded the total amount of 38,000 euros in an attempt to stimulate birth rate in Serbia. In 2006 workers had 38 babies, ten more than the previous year. For each newborn the worker received 500 euros and for every next child, a thousand euros (*Za prvorodjence po 500 evra*). According to the said daily newspaper, the board of directors of this factory decided to award 500 euros to the first baby born in 2007 in the hospital in Gornji Milanovac.

A great number of Serbian people, especially those with strong national feelings, tend to think that giving birth to as many children as possible is one of the noblest causes there are and a duty of every Serbian woman. In addition, many believe that consciously deciding not to have children is a sin and an act of utmost selfishness. Some of the comments directed by passersby at the members of Belgrade-based women’s organization Women in Black, which propagates women’s rights, including the right to abortion, during their protest were: “You are not Serbian women, because if you were, you would be bearing Serbian sons for Serbian vengeance,” “You are barren Yugoslavs and you want, as the communists did, to destroy the Serbian nation” or “Child murderesses, barren women, sterile lesbians” (Zajovic 2002). While not all public comments are this harsh, there is a common attitude towards women who do not want to have children in Serbia as extremely selfish and those in favor of abortion are considered

sinful and working against the best interests of Serbian people. In addition, women in Serbia are, even in the case of involuntary sterility, often considered deviant.

2.3.5 Motherhood Discourse

The ‘motherhood’ discourse is still widespread (even though not as powerful as in the previous decades) in Serbia today, “as a consequence of market economy and liberal democracy [following communism], as well as under influence of nationalism and militarization of the society” (Nikolic-Ristanovic, 2002, p. 54). One of the most powerful cultural models offered to Serbian women during the 1990s was a role of a self-sacrificing mother, which was particularly salient due to the war in Bosnia and Croatia in which Serbia participated. The Serbian Orthodox Church incessantly and robustly propagated the great significance of motherhood for women and its importance for the life of the entire (Serbian) nation (Nikolic-Ristanovic, 2002, p. 59). In a public address to the nation for Christmas 1995, telecasted by all the major Serbian media and later published and republished by all the chief newspapers, the head of the Serbian Orthodox Church, Patriarch Pavle, made an appeal to Serbian women “to stop killing [their] unborn children, to bear more children despite economic hardship, and to learn from mothers who lost their only sons in the war and now regret not bearing more sons who could bring them consolation” (Nikolic-Ristanovic, 2002, p. 59). Unlike his previous messages directed “universally” to the entire nation, Man, and the People, the direct target audience of this particular address were Serbian women, whose attention had to be drawn to a “dangerous phenomenon” Patriarch identified as “a widespread epidemic,” threatening the contemporary world including, “unfortunately, the Serbian

nation, namely, a declining birthrate” (Pacic, 1999, p. 160). Similar to many Serbian nationalist demagogues, Patriarch Pavle referred to it as “The White Plague,” “ascribing it to the social repercussions of industrial civilization, and warned that as the mean Serbian age increases, Serbia’s most vital instrument of its present and future power, its ability to reproduce itself, is ‘endangered’” (Pacic, 1999, p. 160). As Pacic further explains, “this ‘disease’ [...] can only be cured in one way, which is by *making* Serbian women *want* to bear children” (1999, p. 160, emphasis in the original). In his address to the women of Serbia, the Patriarch further claimed that this goal could be achieved if women were aware of the fact that by not bearing (more) children they are committing a threefold sin: towards themselves (as Serbian women), towards the Serbian nation as a whole, and, naturally, towards God himself:

Sin one: “Many mothers who did not want *more* than one child today bitterly weep and pull their hair in despair over the loss of their only son in the war [...] Why did they not give birth to more children and now have them as consolation?”

Sin two: “If such a birthrate continues, the Serbs will become an ethnic minority in their own country.”

Sin three: “Those mothers who never allowed their children to be born will meet them when they come to meet God, where they will ask their would-have-been mother, “Why did you kill me? Why did you not let me live?”

(Daily newspaper *Politika*, 6 January 1995, as cited in Pacic, 1990, p. 161)

Patriarch Pavle was not the only representative of the Serbian Orthodox Church who felt obliged to remind Serbian women of their “sins.” In 1993, Vasilije Kacavenda, Bishop of Zvornik and Tuzla and a cabinet minister on the government of the Republic of Srpska (the Serbian political entity in Bosnia), campaigned for totally outlawing abortion in the Republic of Srpska, claiming that:

Today, to our misery and shame, many Serbian women kill their children. That is why the percentage of Serbian population decreases with every census. In today’s Serbia only 63% of the population are Serbs. [...] If we listen to the advice of feminists and others who support the killing of unborn children, the new census will in a few years show that in Serbia and everywhere where Serbs live this percentage is even lower. This will go on until, God forbid, Serbs in Serbia become a minority and no longer live in their own country. Due to this state of affairs, Serbs have no right to blame others; they will be themselves to blame for their vanishing. (Daily newspaper *Politika*, 27 March 1993, as cited in Shiffman, Skrabalo, & Subotic, 2002, p. 628)

In response to the Serbian Orthodox Church’s call for the banning of abortion, a number of feminist groups protested on the streets of Belgrade. In the same article published in Serbian daily newspaper *Politika*, Bishop Kacavenda refers to these women as “the enemies of the Serbian people,” stating that “these women who have been protesting are not Serbian Orthodox women, they do not have anything in common with the natural essence of the Serbian people”(27 March 1993).

As Zajovic (1995) reports, the Serbian Orthodox Church also envisaged natural punishments for women who do not bear children. As Zajovic (1995) further states, “Women who bear children,” claims [Serbian] Bishop Nikolai in a widely-distributed street poster, “seldom get cancer. And the more children they have, the more they are immune to this horrible disease. Spinsters and women who prevent childbirth are by more than 40 percent more often afflicted by cancer, particularly breast cancer, than women who have children.”

The Serbian Orthodox Church was not the only social institution in Serbia at the time to employ this kind of rhetoric—the ruling Socialist Party of Serbia, with Slobodan Milosevic as its head, in cooperation with the greatly reputable Serbian Academy of Arts and Sciences and the Serbian Medical Society, in 1992 published a *Warning on the Demographic Movements of the Serbian Population*, which cautioned the population of Serbia that “Without offspring there is no family, without kin there is no nation!” (October 1992, p.1). However, male-dominated social and political structures were not alone in utilizing this kind of discourse; certain women groups took part in it as well. For instance, a group of young right-wing nationalist women founded a women’s group entitled “Only a Serbian woman can save a Serbian man” (a word play based on the historical Serbian motto “Only unity can save the Serb”) and supported the notion that “good” Serbian women are primarily required to perform their duties in the private domain. Isidora Bjelica, a woman novelist and one of the group’s founders, publicly stated that one of the most significant characteristics of national identity for Serbian women is their ability “to create little Serbs,” and that the solution for all the problems

lies “in a return to traditional patriarchal values of motherhood, sacrifice, and submission” (Bracewell, 1996, p. 29).

On the other hand, cultural values offered to men in the 1980s and 1990s were predominantly those of military heroism, machismo, aggression, and nationalism. Clearly, promoting such values and making them dominant in Serbian society resulted in reinforcement of “gender stereotypes in which men play the active role of defending the homeland, while women are confined to the passive, private sphere, as nurturing—and often bereft—wives, and above all, *mothers*” (Hawkesworth, 2000, p. 2).

Throughout Serbian history from the Middle Ages onwards, women were, without a doubt, considered inferior to men. However, through behavioral norms established through customs and rituals, “women were invested with a positive value in traditional society which recognized the interdependence of women and men and in which the concept of motherhood was particularly powerful” (Hawkesworth, 2000, p. 2). As a result of political and economic crisis in modern Serbia (reinforced by the U.N. economic sanctions and bombing of the Serbian capital Belgrade in 1999), as well as the many other struggles of the people during the difficult period of transition, Serbian reality was “marked by a deep-seated nationalism which tends to foster ideas of women as *reproductive instruments* for providing the nation with sons” (Hawkesworth, 2000, p. 13). As a consequence of the mythic interpretation of Serbian history and the role of women in it, a publicly accepted, predominant model of womanhood was created. Undoubtedly, “in the context of dominant nationalist ideology, women have been ‘trapped’ in a fundamentally male perception of their history, culture, and identity”

(Hawkesworth, 2000, p. 25). Furthermore, the power of the social construction of motherhood and historical heritage of representing women primarily as mothers and wives in Serbia is further reflected in the language itself. In Serbian language, similarly to other Slavonic languages, as well as Hebrew and Greek, the word for ‘woman’ (Serbian: *zena*) is the same as the one used to denote a ‘wife,’ presumably one who can bear children. In other words, based on the social construction of feminine and femininity in patriarchal societies and as a result of socially constructed beliefs and symbols, a woman who does not possess either womb or ovaries (or both), and therefore is unable to reproduce, may not be considered female at all (Elson, 2004, p. 5).

2.4 Masculinity vs. Femininity in Serbia

The nationalist restoration of the institution of patriarchy brought into play, reinforced, and produced a unique Serbian neo-nationalist patriarchy, without a doubt molded by the hand of Slobodan Milosevic. Under the rule of Milosevic, both nationalist and patriarchal authoritarianism was regularly exercised, with the foundation of its power in the survival and consequent revival of a collective identity, which was to give the ultimate power to the leader of the nation himself. This reconstructed, post-communist patriarchy, which contained military, collectivistic and authoritarian components, was partially based on the traditional gender system, with a specific focus on “hegemonic masculinity” and “emphasized femininity” (Messerschmidt, 1997). According to Cheng (1999), hegemonic masculinity is characterized by a number of attributes such as “domination, aggressiveness, competitiveness, athletic prowess, stoicism, and control. Aggressive behavior, if not outright physical violence, is important

to the presentation of hegemonic masculinity.” On the other hand, Connell (1987) defines emphasized femininity as that which exists in relation to female subordination to men and is exclusively focused to the interests and desires of men. Furthermore, the concept of emphasized femininity places special importance on the role of women as reproducers and nurturers. As Cheng (1999) states, one of the functions of emphasized femininity is to “please hegemonically masculine men and make them appear more hegemonically masculine—to make them feel stronger, wiser, more competent.”

According to Messerschmidt (1997), “Hegemonic masculinity and emphasized femininity are the dominant forms of gender to which other types of masculinity and femininity are subordinated or opposed, not eliminated, and each provides the primary basis for relationships among men and women” (p. 10). According to Connell (1995), the crisis of gender order or its tendency towards crises may provoke attempts towards restoring a dominant masculinity. As Connell (1995) further argues, hegemonic masculinity is closely related to the military. This created a militarized gender order in the former Yugoslavia, which included exploitation of military rituals, national flags, music, weapons and uniforms in the media and in everyday life. In Serbia, similar to the militaristic images deployed in other countries, “cultural models of masculinity which were, as in other wars, offered during and after the war, included those of soldier, breadwinner, and family man” (Hatty, 2000, p. 139, as cited in Nikolic-Ristanovic, 2002, p. 59). On the other hand,

Complementary femininity models included women’s sacrifice as mothers and wives as well as women as sexual objects [...]. Hence militarized (hegemonic)

masculinity and emphasized femininity served as the most powerful cultural models offered to Serbian men and women during most of the 1990s. (Nikolic-Ristanovic, 2002, p. 59)

The nationalist and nation-building rhetoric of Serbian leaders (especially Milosevic) was first and foremost aimed at men in an attempt to deconstruct the former communist notion of masculinity and reconstruct a new militarized, nationalist concept of masculinity. This ideology perfectly fits the ethnic mythology of Serbian men as, if not romanticized, then “natural” and perpetual warriors. This type of militant, “macho” discourse rendered women in Serbia almost invisible, practically erasing them from public discourse, except as “natural baby-producing-machines” for the sake of the collective good. As Jamieson points out, “we can speak about the re-ordering of gender in the context of war, or about the prevailing norm about the gendered division of labor in war which calls on men to do the fighting [...] and on women to do the waiting and self-sacrificing” (1998, p. 495-6, as cited in Nikolic-Ristanovic, 2002, p. 59).

Even though Serbia was not officially in the state of war with other former Yugoslav republics in the 1980s, Serbian people had to face a savage deconstruction of their socio-cultural identity, resulting in severe degradation of basic human values, as well as personal identities of its inhabitants. Under those circumstances, women were willingly transferred into a ‘self-sacrificing’ mode of behavior and became the ‘backbones’ of their families. During the U.N. sanctions throughout most of the 1990s, about three quarters of women in Serbia on average held three jobs (paid work; housewife and mother; and an additional job, frequently in black market trade). A

significant number of women were (and still are) exposed to family violence (as illustrated by a traditional saying “I am beating you and you know why”) and were indoctrinated into the endless cycle of self-sacrificing.

As Kotzeva (1999a, p. 85) states, with the restoration of male dominance in post-communist societies, “public images of women appeared as two conflicting images consisting of the image of the New (Amazon) Woman (or superwoman, omnipotent woman) and the traditional image of woman as housewife and mother (as cited in Nikolic-Ristanovic, 2002, p. 53). Consequently, Serbian women found themselves faced with a multiple personality syndrome, simultaneously juggling multiple identities—that of a subordinate and meek creature, excellent cook, responsible and economical housewife, loving mother, but also that of an educated conversationist (preferably with a university degree), and a business woman who earns money, is sexually liberal, and fits the image of beauty and sex appeal, as presented by the media.

2.4.1 Female and Male Sexuality in Post-Communist Serbia

During the communist era in all the countries of the Eastern block, “[s]ince the socialist East was suspicious of the excessive pleasures and sexual freedom of the ‘decadent’ West, it strictly controlled women’s sexuality and eroticism so that chaste women were presented as the symbols of a new spirit of communist-style Puritanism and abandonment of passions and desires” (Kotzeva, 1999, p. 85, as cited in Nikolic-Ristanovic, 2002, p. 59). According to Nikolic-Ristanovic (2002), male sexuality was, at the same time, suppressed as well. I remember my grandfather’s story, from his “partisan days”, about a brutal and immediate execution of a man and a woman, Party

comrades and fellow-partisans, who were found in a barn in Vojvodina, a rural part of Serbia, making love. Such “offenses” against the Party were instantaneously sanctioned in those days, in order to serve as examples to the other Party members. However, with the dying out of communist doctrine in the former Yugoslavia, though inconceivable by the former regime, a real explosion of beauty/fashion magazines and pornography took place. That was a true sign of “liberation”, since as Nikolic-Ristanovic (2002) states, “due to strict rules during communism, in the majority of post-communist countries pornography did not exist at all” (p. 59).

In the era following the reign of communism, one of the first signs of “Westernization” of the society was the expansion of pornographic materials of different kinds, as a symbol of new freedom and democratization. According to Nikolic-Ristanovic (2002), “suppression of sexuality during communism, more or less, delayed the sexual revolution in all countries so that social changes were seen as an opportunity to compensate for all that was missed for so long, as well as for achieving individual instead of collective identity (p. 60). As Connell puts it, this phenomenon “has to do with a new structure of cathexis centering on what might be called hegemonic heterosexuality” (1987, p. 157). Simultaneously, as well noticed by Nikolic-Ristanovic (2002), “global mass media additionally reinforced this trend through circulation of stereotyped gender images” (p. 60), which were “deliberately made attractive for marketing purposes” (Connell, 2001, p. 61, as cited in Nikolic-Ristanovic, 2002, p. 60).

At the same time, sexuality within the institution of marriage was and still is considered a taboo. As Savic (2003) states in her article, sexual choices represent one of

the greatest taboos in Serbia and both men and women discuss these issues very reluctantly. This is especially true for women; they can confide in their close female friends about their sexual experiences, but in a larger company one would certainly not hear a woman talking about her desires in the way a man would. If she ever did that, she would be considered immoral and loose. That sexuality is considered a taboo is also evident in Serbian movies in which sexual and love scenes are almost nonexistent, except in the case of violent and brutal sexual intercourse. Moreover, in Serbian swearwords or curses sex is typically used as a threat. As cited in the same article, Dr. Vlada Milosevic, a neuropsychiatrist, states that public abolition of sex and sexuality related taboos in Serbia is performed in a banal and vulgar manner, so that sex will remain a taboo in Serbia, especially with women.

Furthermore, sexual love within marriage and marital love in general represent another taboo in Serbian culture. According to the above mentioned article, which is confirmed by my personal experience, people in Serbia tend to talk about their lovers and extramarital affairs in public more frequently than about their husbands or wives. It is even considered shameful to discuss or admit one's passionate love for one's husband/wife in front of others. As Serbian woman novelist Isidora Bjelica states, "Infidelity is something that is cultivated [in Serbia], while great and openly expressed marital love is disapproved of" (Savic, 2003). The reason for this may be that, typically, marriage in Serbia serves the primary purpose of establishing a family structure, i.e., the purpose of providing offspring, so it is child-centered, not partner-centered. As Blagojevic (1996) affirms, parenthood in Serbia is central to family life, and partnership

is defined through and by parenthood. Additionally, as previously stated, both men and women in Serbia “largely were, and still are, defining parenthood as the meaning of their life” (Blagojevic, 1996, p. 630).

2.4.1.1 Pornography in Post-Communist Serbia

When recently asked by a (female) journalist what he thought about the position of women in Serbia, a (male) politician replied tongue-in-cheek: “Many positions can be viewed as acceptable, but I find Serbian women to be the best in the horizontal position.” As Nikolic-Ristanovic, (2002) explains it, “In post-communist society media [and the public scene] re-constructed the traditional opposition between men’s sexual needs and women as passive sexual objects and men’s property, which is further used to justify violence and blame the victim” (p. 60). In spite of being a child at the time, I clearly remember the ‘explosion of pornography’ in Serbia in the 1980s and 1990s. Pictures of naked or semi-naked women in provocative, sometimes suggestive and sometimes openly sexual, positions were published in daily newspapers, frequently even on front pages. It was a “special treat” for the male population of all ages, clearly indicating that all men in Serbia (at least those reading daily news) are to be considered “real men” who would find such materials attractive and exciting. Pornographic literature was sold freely on the newsstands, which my friends and I would see on regular basis when coming home from school. It was a part of our reality, a symbol of sudden democratization of the society long burdened with the communist asexual doctrine. In many ways it shaped women’s view of their own female sexuality.

In Serbia, as well as in other post-communist societies, pornography was not limited to pornographic magazines and newspapers only. It was also present on television, in popular music, advertisements, movies and other forms of popular culture. As Nikolic-Ristanovic (2002) argues, “It seems that presentation of sexuality shifted from images of women and men as asexual or partly sexual beings (in Communism) to images of hegemonic masculinity and emphasized femininity associated with traditional opposition between men’s (uncontrollable) sexual needs and women as passive sexual objects” (p. 61). However, as many authors point out, pornography represents a form of violence against women, can be defined as “erotisation of women’s subordination” (Jeffrey, as cited in Attwood, 1996, p. 259), and may give rise to other types of violence against women.

2.4.2 Domestic Violence in Post-Communist Serbia

According to a recent research project conducted by UNICEF (1999), domestic violence is prevalent and represents a severe problem in post-communist societies, with a tendency to increase and become even more serious (p. 80-83). According to Nikolic-Ristanovic (2002), “All research findings seem to provide evidence for the assumption that everyday life changes brought on by the transition from a planned market economy, further aggravated in some countries by ethnic conflicts and war, contributed significantly to women’s vulnerability to violence at home” (p. 75). As Nikolic-Ristanovic (1998, p. 473) further reports, “the only prevalence study on domestic violence carried out in Serbia is the research on spouse abuse conducted in 1993. The research was based on the sample of 192 women chosen at random from the general

population in Belgrade [the capital]” (as cited in Nikolic-Ristanovic, 2002, p. 79).

According to the said research, more than half of the women surveyed (58.3 %), reported that they were victims of some sort of spousal abuse. Forty-nine percent of the women participants in the research reported psychological abuse, while 18.7% reported that they were victims of physical abuse by men. Furthermore, 18,7% of the women surveyed reported that they were raped at least once by their husbands (Nikolic-Ristanovic, 2002, p. 79). However, even the women who reported to be victims of wife battery were frequently reluctant to label it as abuse or violence, and evaded answering more concrete questions posed by the interviewees. As Nikolic-Ristanovic (2002) states, these results “may prove the high degree of tolerance of violence as a consequence of the generally strong patriarchal structure of the Yugoslav [Serbian] family, e.g. learning that it is normal for a woman to suffer violence, especially psychological violence, from her husband” (p. 79).

Data from various sources indicate that poverty, as well as sudden and abrupt changes in economic and social status, combined with a high level of instability and the complexity of making even simple decisions under those circumstances, caused a very high level of social frustration and stress and contributed to deterioration and disorganization of family relationships, as well as to the increase in the number of cases of family violence and wife abuse (Jovanovski, 1998, p. 91; Coneva, 1998, p. 134; Milosavljevic, 1999; Polovina, 1999; Zegarac and Brkic, 1998, p. 23; Zlatanova, 2001, p. 33, as cited in Nikolic-Ristanovic, 2002, p. 83).

Unemployment and excessive poverty lead to greater dependence of women on men than before. As Nikolic-Ristanovic (2002) states, “This model seems to prevail among couples where violence occurs, suggesting a connection between domestication of women and a renewed traditionalism of gender roles on one hand, and domestic violence, on the other hand” (p. 84). As Andersen (1988, p. 78, as cited by Nikolic-Ristanovic, 2002, p. 84) argues, this is in accord with the postulation that traditional gender roles of men and women serve as dividing mechanisms, at the same time creating an encouraging atmosphere for violence to take place, as well as “decreasing the economic and social potential for women to leave the molester” (Nikolic-Ristanovic and Milivojevic, 2000; Caceva and Coneva, 2000, p. 65, as cited in Nikolic-Ristanovic, 2002, p. 84).

Paradoxically, better economic and social status of women may have a similar negative effect “when an increase in women’s economic status creates status incompatibility and leads to “a most unusual family class relation” (Hagan, 1988, p. 172)—where the man is either unemployed or employed in a position without authority, while the wife is employed in a position with authority (Nikolic-Ristanovic, 2002, p. 85). Under such circumstances, which do not correspond to the traditional structure of home environment, besides the inability of men to fulfill the traditional role of breadwinners, they are also faced with prolonged periods of passivity (due to unemployment) and spending long hours in the house, which frequently results in violent behavior of men towards women. As Dicks et al. (1998, p. 296) point out, the presence of the man in the house is considered “alien and disruptive;” home being the exclusive realm of the

woman, it is frequently the woman who must suffer the consequence of this ‘unnatural’ order of things.

In spite of the brutal violence, women from post-communist societies often choose to remain with their abusive husbands or partners. As interviews conducted by Bethlen and Minkova (1999) show, “The reason may be fear but also patriarchal expectations for the woman to stay married whatever her relationship with the husband” (as cited in Nikolic-Ristanovic, 2002, p. 101). Having that in mind, the report of the *United Nations Development Program* in Sofia, Bulgaria sheds even more light on the issue:

It is easy to understand why women beaten by their husbands keep silent on the matter. They feel shame, humiliation, and lack of understanding even on the part of their relatives and friends, and finally, the hopelessness of the situation (as cited in Minnesota Advocates, 1996).

The answer to the mystery of frequency of family violence over women in post-communist Eastern European countries such as Serbia, most probably lies in the very root of patriarchal social construction which empowers the male and renders the female not only voiceless, but frequently even utterly invisible in the society. As Messerschmidt argues, “wife beaters (regardless of their class and race position) presume they have the patriarchal right—because it is part of their ‘essential nature’—to dominate and control their wives, and wife beating serves both to ensure continued compliance with their commands and as a resource for constructing a ‘damaged’ patriarchal masculinity” (1993, p. 147).

2.5 Concluding Remarks

The reasons for dominance of patriarchy and hegemonic masculinity in Serbia and the Balkans lies in the region's cultural heritage, manifesting itself in three components: "the influence of the Orthodox Christian Church, with its Byzantine background; the presence of Islam in the particular form it took in the Balkans; and the basic social structure of the *zadruga*—the patriarchal extended family farm, which set the basic pattern of life in most of the [Serbian] countryside, at least until the Second World War" (Hawkesworth, 2000, p. 11).

Throughout Serbian history, the hegemony of the masculine over the feminine has been obvious, starting from the hierarchical organization of the household, to the ancient "mechanisms for reinforcing the domination of the male-oriented group over its female members: for example, in public the man must be seen to assert his authority by walking in front of his wife, or riding the only donkey while the women carry heavy loads" and other forms of symbolic representations of masculinity/femininity, such as "seating arrangements on ceremonial occasions, and the frequent custom of the women of the household kissing the men's hands or, in some places, washing their feet" (Hawkesworth, 2000, pp. 11-12). As Hawkesworth (2000) further states, "whatever the private reality for individuals at various times [in the history], all these cultural influences have tended to reinforce an unstated but pervasive public perception of women's inferiority" (p. 12).

Even though some public (predominantly male) agitators in Serbia today may claim that the current situation is nothing like it used to be in our "dark past" and that the

entire “women’s question” has been successfully solved with the fall of Slobodan Milosevic and the rise of new Democratic power, we are still far from, certainly not complete, but even an acceptable gender equality level. The re-establishment of the traditional patriarchal values and hierarchy after the communist period and its further reinforcement after the civil war in the former Yugoslavia, marked by severe economic, political, and social crisis in Serbia and other countries in the region, once again marginalized women and left them battered and voiceless.

Giving a new voice to the women in Serbia and other countries in the Balkans and Eastern Europe is one of the most important tasks that new Democratic powers have ahead of them in the years to come.

In relation to my own study of hysterectomy and gender identity among Serbian women, all the aforementioned aspects of life in Serbia, such as historical, sociological, and economic circumstances; cultural and mythological implications; publicly communicated and widely promoted motherhood discourses; as well as generally accepted ideas about female and male sexuality, have greatly influenced Serbian women throughout the years and impacted their gender identity and sense of self in numerous ways. In many cases, women who have undergone hysterectomy find themselves even more than usually affected by these stereotypical representations of women in Serbia due to the very nature of the surgery which requires removal of female reproductive organs. I address this issue in greater detail in Chapter IV in which I discuss individual stories of women who have participated in my study and how their experience of hysterectomy is related to their body image formation, experience of disease, femininity, sexuality,

culture, personal relationships, and gender identity dilemmas. I now turn to Chapter III in which I will describe my study design and how I went about collecting data for this project.

CHAPTER III

LITERATURE REVIEW AND METHODOLOGY

3.1 Literature Review

In the following chapter I provide a short literature review and address the background of the problem I tackle in my thesis, i.e. hysterectomy procedure and the influence it may have on women and their sense of self and gender identity, in relation to cultural and communication issues. Furthermore, I briefly discuss cultural implications of hysterectomy and address the link between motherhood and hysterectomy in Serbia. Finally, I provide the description of the methodology I use in my own study for recruiting my respondents and for conducting in-depth interviews with women in Serbia.

3.1.1 Background of the Problem

As stated previously in this account (Chapter I, Definition of Terms), hysterectomy is a procedure which involves the surgical removal of a woman's uterus, and is performed either in order to treat non-malignant conditions such as "fibroids, heavy bleeding, endometriosis/adenomyosis and prolapse" (Vomvolaki et al., 2006, p.23) or is suggested to the female patient based on the physician's suspicion of malignant growth. Hysterectomy is traditionally viewed as a procedure associated with a high level of emotional stress in women, although more recent studies of American and Canadian women (e.g. Lambden et al., 1997; Khastgir & Studd, 1998; Thorton et al., 1997, etc.) show that there are strong psycho-sexual or psychological effects for somewhere between 10-20% of women who have had this procedure, "who report negative psychosocial outcomes such as reduced sexual interest, arousal, and orgasm, as

well as elevated depressive symptoms and impaired body image” (Flory, Bissonnette, & Binik, 2005, p. 117). Incidences of depression, impaired gender identity and sense of self, as well as other emotional and psychological problems that may arise following a hysterectomy procedure should by no means be neglected. Emotional and psychological problems that may occur subsequent to the hysterectomy procedure depend on a number of different factors, such as “childbearing status (completed childbearing, hoping for a child or further children); psychological well-being and outlook before the operation; symptom relief; and post-surgery complications or side effects (such as those associated with an instant menopause” (Vomvolaki et al., 2006, p. 23).

Another important factor that may influence the way women perceive themselves after the hysterectomy is the quality of their relationship with their relational partners, spouses and/or significant others. Even though there is a lack of research on men’s views about hysterectomy, several studies have been conducted to explore the role of relational partners in American women’s coping with the hysterectomy procedure (Wolf, 1970; Bernhard 1992; Bernhard & Harris, 1997; Williams & Clark, 2000, Elson, 2004).

Wolf (1970) asserts that in his medical practice he was able to observe a number of men who had substantial anxiety about their spouses having a hysterectomy. These men even believed their own sexual identity was jeopardized because their spouses would cease to be “women” due to the surgical removal of their uteri.

In her study on men’s views on hysterectomies and women who have them, Bernhard (1992) reports that men are generally not knowledgeable about hysterectomy and her findings show that they viewed hysterectomies and women who have them

negatively, even though most of them admitted their ignorance. Furthermore, the majority of participants in the study believed that women's sexuality is lessened by having a hysterectomy, that they have less sex appeal, and are generally less satisfying to their male partners. Some men even stated that they believed they would be less able to perform sexually since hysterectomy could create impotency in men. Finally, the results of the study showed that men communicate very little with their female partners or health care professionals about hysterectomy.

In their study about partner communication about hysterectomy, Bernhard and Harris (1997) affirm that spousal communication about a woman's hysterectomy can be difficult and serve as a source of disharmony and marital conflict. Findings of this study show that men typically tend to avoid feelings and try to keep out of discussions of hysterectomy. Even though couples reported good communication about hysterectomy, analysis revealed that there was actually very little communication about the hysterectomy between the partners.

Williams & Clark (2000) assert that although most of the participants in their qualitative study, which included focus groups and individual interviews, described their hysterectomy experience as positive, they expressed a variety of concerns, from diagnosis through recovery. According to the authors' findings, which are consistent with the results of Bernhard's (1992) study, many male partners are happy to leave the decision for surgery to their female partner. Additionally, the article briefly discusses that many African American participants reported that their spouses, brothers, uncles and male friends of the same ethnicity were non-supportive and several African American

respondents shared that they had not informed a new partner about the hysterectomy to avoid the negative reactions.

Probably the most comprehensive study recently conducted on hysterectomy and gender identity was conducted by Elson (2004), which addresses her respondents' post-surgery identity struggles in relation to hysterectomy procedure. Through her extensive qualitative research, notably interviews with forty-four women, she makes an obvious contribution to medical sociology and the sociology of gender, but primarily directs her book towards women who have undergone gynecological surgery as well as those who may face such surgery in the future. Even though Elson's book represents the most inclusive qualitative study recently published on the ways in which American women cope with hysterectomy, it does not contain any cross-cultural comparisons or references to cultural, racial, or ethnic factors as possible determinants of the participants' experience with hysterectomy.

3.1.1.1 Culture, Race and Ethnicity

Several past studies note that African Americans, especially males, have particularly negative attitudes toward hysterectomy and women who have undergone it (Bernhard, 1985; Bernhard, 1992; Williams & Clark, 2000; Richter et al., 2000; Augustus, 2002). Many African American women who participated in these studies reported being afraid to admit to their husbands, partners, or other African American men that they had a hysterectomy, since men are "somewhat superstitious about hysterectomy, believing in myths and old wives' tales" (Richter et al., 2000, p. S56). Women also reported that African American men tend to use a number of derogatory

and negative terms, such as “dry pit,” “empty shell,” “mute”, “dried out,” and “bottomless hole” to indicate a woman whose uterus has been removed due to hysterectomy (Richter et al., 2000). Some African American men even believe they would become impotent if they had sex with a hysterectomized⁷ woman, whom they perceive as “less of a woman,” or “not a whole woman,” and tend to terminate a relationship after learning of the woman’s hysterectomy, which leads African American women to avoid telling their partners of the procedure.

Several studies included attitudes of Hispanic women towards hysterectomies (Galavotti & Richter, 2000; Groff et. al., 2000; Brett & Higgins, 2003), which also include women’s concerns about men’s negative attitudes towards women who had hysterectomies; however Hispanic women in Texas felt their own partner or husband would be supportive. Furthermore, “Hispanic women in Texas who had not had a hysterectomy, mentioned that the procedure might lead to depression and grief over the loss of childbearing capacity” (Galavotti & Richter, 2000, p. S-64). Groff et al. (2000) reiterate these findings and assert that Hispanic women in their study “had many ideas about the possible negative effects of hysterectomy, but psychological problems, especially “depression,” sadness, and crying, were mentioned often” (p. S-43). The same authors report that Hispanic women also discussed lack of sexual desire, vaginal dryness, and sadness over the loss of childbearing ability as possible problems they

⁷ This is a term that authors of the article use, and it is fairly common in related literature, but I made an effort to depart from it in this report because I believe it sounds derogatory, strips women of agency, and disempowers them.

would expect. However, none of the participants in this study actually had a hysterectomy, even though they knew other women who did.

Brett & Higgins's study (2003) primarily discussed the prevalence of hysterectomy among several ethnic groups, including Hispanics, but does not address the women's feelings or attitudes towards hysterectomy or cultural practices related to the procedure. The findings of the study show that Hispanic women are much less likely to undergo hysterectomy than are non-Hispanic White women.

One study (Lalinec-Michaud & Engelsmann, 1989) addressed the role of cultural background in the etiology of depressive symptoms associated with hysterectomy in French Canadian, English Canadian, and women of European descent in Canada. According to these results, English Canadian were least likely to experience depression following a hysterectomy, French-Canadian were more likely to have higher depression scores than English-Canadian women, while women of (unidentified) European descent were most likely to experience instances of depression. European women were also most likely to express regrets about the loss of childbearing ability and more often perceived hysterectomy as a threat for their femininity and self-concept than women from the other two groups. According to the authors, the reason for this may be found in women's religion of origin, where Roman Catholics (French-Canadian and European women) and Orthodox Christians (European Women) were more likely to place greater importance on the role of the woman as wife and mother, rather than her role in larger society, while Protestants (English-Canadian women), in contrast, "put more emphasis on personal

achievement and work outside the home,” so therefore “hysterectomy may have less impact on them” (p. 169).

However, no systematic research that would include other racial and ethnic groups besides White Americans, African Americans, and Hispanics in the U.S. and French Canadian, English Canadian, and women of European descent in Canada has been conducted.

In view of the limited number of recently conducted studies addressing the aforementioned aspects of hysterectomy experience and the limited racial/ethnic and cultural samples, there is clearly a need for more research on the ways in which culture, ethnicity, and/or race can influence women’s attitudes toward hysterectomy, affect their gender identity, as well as their male partners’ reactions to it. Furthermore, most previous studies mainly deal with either psychiatric, medical, and/or public health issues, and only a few, not-very-recent studies (Bernhard, 1992 and Bernhard & Harris, 1997) approach this matter from a communication (e.g., relational) point of view, so communication issues also need to be further addressed in future studies.

3.1.1.2 The Case of Serbia

Most of the research conducted on the above-discussed issues has been published in the U.S. and by American authors, with the exception of a few studies conducted in Canada (Lalinec-Michaud & Engelsmann, 1989; Flory et al., 2005) and one study published by the researchers at University Medical School in Athens, Greece (Vomvolaki et al., 2006), which did not include experiences of Greek women with

hysterectomy, but only reported on findings of a number of studies the authors selected from MED-LINE, CINAHL, Psychlit, and Sociofile databases.

Additionally, as previously stated, there are very few studies published in Serbia which explore the influence of hysterectomy on women's emotional or psychological well-being and quality of life. Moreover, none of these studies explores either the role of communication with relational partners and the influence it may have on women who have undergone a hysterectomy, or the determining cultural factors, such as the Serbian culture of imperative motherhood.

While it is generally known that hysterectomy is "currently the second most commonly performed surgical procedure in the United States" (Elson, 2004, p.3) and represents "the most frequent non-obstetric surgical procedure among women in the United States" (Brett & Higgins, 2003, p. 307), as previously mentioned in Chapter I of this report, no similar official demographics exist for Serbia. The very lack of such systematic statistical data and the extreme emotional and psychological reactions some of the respondents in my study had to their hysterectomy procedure (very similar to the one my mother's aunt Milka had, as described in Chapter I of this report), further complicated by Serbian cultural heritage which places so much importance on motherhood, indicate that the issue of hysterectomies in Serbia and women's attitudes towards them need to be further explored and given more attention.

One of the rare studies recently conducted in Serbia which deals with psychological effects of hysterectomy on women was conducted by Ljubisa Zlatanovic from the Faculty of Philosophy, University of Nis in 2001. The study explores the

personality characteristics and the mental health problems of nineteen hysterectomy patients who received postoperative treatment at the Day Hospital of the Clinic for Psychiatry in Nis, over a period of three years (1995-1997) (Zlatanovic, 2001).

However, even though the author of this study obtained both quantitative and qualitative research data, which indicated that the hysterectomy procedure can be perceived to significantly affect the women's psychological health (especially their experience of low self-esteem, loneliness, anxiety, and depression), the study failed to mention any of the cultural behaviors and traditions that may have triggered this negative response in the women who participated in the study. Additionally, the study did not include the women's self-perceived gender identity after the surgery, nor their relational status, or type and quality of communication with their relational partners. I believe these cultural and communication issues to be important questions that need to be addressed because they may greatly influence women's reactions to hysterectomy procedure.

3.1.2 Cultural Implications of Hysterectomy

Many cultures, both ancient and modern, associate women's sexual and gender identity with their reproductive organs. According to Laqueur (1990), the female womb and ovaries may frequently be interpreted as a synecdochal symbol of a woman in the totality. As a result of socially constructed beliefs and symbols, a woman who does not possess either womb or ovaries may not be considered female at all (Elson, 2004).

Although many contemporary feminist scholars follow in the footsteps of Judith Butler's (1990) powerful and much-publicized "performative theory of gender" (inspired by Foucault's notion of "discipline" or "surveillance"), which defines gender as a forced

performance imposing a fictitious structure of “core gender” upon the world, in actuality millions of people inhabiting the “real world” still believe that their gender identity not only exists, but also matters a great deal. Many cultural theories define female sexual organs as extremely important and crucial for emotional stability of women. Women, especially those from traditional, patriarchal societies, may consider gender as their primary identity, a personal characteristic especially significant for them.

3.1.2.1 Motherhood and Hysterectomy: Serbian Experience

Many studies have shown that hysterectomy may be even more stressful for women who do not have children or are premenopausal, since they may not have “fulfilled their childbearing potential” (Drelich and Beiber, 1958; Kaltreider et al., 1979; Roeske, 1979). On the other hand, some more recent studies (e.g. Palmer, 1984) demonstrate that the loss of childbearing ability and the anguish following it may not represent such a severe consequence of hysterectomy after all, since motherhood has become a less important component of the contemporary woman’s identity:

Historically, a woman’s self-esteem has been derived primarily from her reproductive functions [...] Currently, social changes have increased women’s expectations of fulfillment outside of motherhood. In fact, the potential for an increased number of sources for status and self-esteem may change the emotional meaning of hysterectomy. (Palmer, 1984, p. 5).

While this may be true in the U.S. and other Western societies, it is certainly not true in a highly pronatalist, traditional, and patriarchal society such as Serbian, where an enormous amount of importance is placed on women’s role as a mother. Furthermore,

even in the less traditional and more liberal societies, more women today postpone childbearing in order to fulfill their other social roles and are therefore more likely to be childless at the time of hysterectomy, which may create significant problems for women undergoing this surgical procedure (Elson 2004).

As stated in the previous chapter, “it seems that the role of woman as mother as well as self-sacrifice of woman for collective aims is central to the ideology of both communism and post-communism. [...] It is also central to the nationalism and war discourse in Serbia, as well as in other parts of the former Yugoslavia” (Nikolic-Ristanovic, 2002, p. 55). For all these and many other, previously discussed reasons, the role of a mother is a publicly accepted model of womanhood in Serbia. This is why it is very likely that the possibility of permanent sterility, which typically follows hysterectomy, may create a strong feeling of dissatisfaction and uncertainty in Serbian women anticipating a hysterectomy, even more so in women with no children. Furthermore, hysterectomy could force these women to face rejection by both society and in some cases their intimate male partners, based on perceptions that the women have not fulfilled their “natural” role as wives/mothers/women, as well as having to cope with their own struggles with their abruptly changed sense of self. Moreover, if a woman from Serbia tries to rationalize the situation she found herself in (coping with hysterectomy and sterility in a society which highly values the notion of motherhood as exceedingly positive, even noble), she may feel uncertain about how to integrate a particular belief (e.g., that hysterectomy would not make her less of a woman) with other, culturally determined beliefs or values, such as the positive and highly desirable,

even obligatory image of motherhood imposed on Serbian women (Babrow, 2001, p. 559).

3.1.2.2 The Role of Communication with Relational Partners

According to Elson's (2004) study on gender identity of women who underwent hysterectomy, "the quality of their relationships with intimate partners was the most significant factor in respondents' stated abilities to maintain or reclaim their gender identities following surgery" (p. 164). Furthermore, according to Rosenberg, "sustained intimate relationships are particularly important to identity because "the opinions of those people who matter most to us—whose opinion we care about greatly [...] have a stronger effect on our self-concepts than the views of those to whom we are indifferent" (1981, p. 598). Moreover, Blumstein states that, "identities that are enacted in intimate relationships should have important implications for the self" (1975, p. 308).

Some may assume that the focus of the hysterectomy experience is the woman herself; however, while "on the surface a hysterectomy may appear to be a biological event for a woman [...] it is also a psychological event for the woman, couple, and family, which can result in both sexual and relational changes" (Darling & McKoy-Smith, 1993). Furthermore, some previous studies indicated that the reactions of husbands and/or male partners to women's hysterectomies were very significant in determining the level of women's (both physiological and psychological) recovery after the surgery (Elson, 2004).

According to Hines (2001) "communication plays a central role in person's efforts to cope with illness-related uncertainties," while other researchers argue that

“communication is the source of most uncertainties that persons with illness experience” (Babrow, 2001; Babrow et al. 1998, Brashers et al., 2000, as cited in Hines, 2001, pp. 500-1). Communication with her husband or a male partner may cause a woman to develop an even greater feeling of uncertainty regarding the outcome of the gynecological surgery, because her relational partner during their communication may voice concerns that were not even imagined by the women in question, thus making her coping with existing and novel uncertainties even more difficult.

On the other hand, communication may also be perceived as a central coping strategy concerning illness-related uncertainties. According to Hines (2001), “whereas communication creates most such uncertainties, it also is the primary means by which persons attempt to cope with them” (p. 501). However, “even when another understands a person’s uncertainties, a failure to understand the form of the person’s uncertainty may compromise well-intentioned efforts to facilitate coping” (Hines, 2001, p. 501). Some women, especially those from patriarchal cultures such as Serbian, may find it difficult (due to shame, insecurity, or social stigmatization) to talk to their partners or physicians about the exact nature of their uncertainty when anticipating or following a hysterectomy, which may lead to serious misunderstandings and increase the level of uncertainty, instead of lowering it.

In summary, both cultural background and communication with relational partners may have a significant influence on women who have undergone hysterectomy and their sense of self and self-perceived gender identity, and therefore need to be further addressed. For this reason, my own research adds a new component to the

existing research and will hopefully provide additional insight into Serbian women's experience of hysterectomy and hysterectomy experiences of women in general.

3.2 Methodology

3.2.1 Introduction

The purpose of this research study was to examine the impact of surgical removal of the uterus, i.e. hysterectomy, on gender identity of Serbian women, as determined by their cultural background and the quality of communication with their relational partners. Since my main research interest focuses on women's lived experiences, I chose an interpretive field research method as the most suitable for my purpose.

3.2.2 Method

A Glaserian grounded theory approach was adopted (Glaser & Strauss 1967, Glaser 1978, 1992), aiming at developing a substantive theory based on the experiences of the participants to explain how Serbian culture, especially traditional motherhood discourse, impacts the gender identity of Serbian women; how women who have undergone hysterectomy perceive themselves after the surgery and how that perception influences their sense of self, gender identity, and sexuality; how these women communicate their gender identity to the people surrounding them, especially current and potential romantic partners; and how communication with their relational partners helps improve or diminish their emotional status after hysterectomy.

I decided to use the grounded theory approach, which is inductively developed from a corpus of gathered data by discovering or labeling categories, subcategories, and their interrelationships, i.e. by identifying, naming, comparing, categorizing, describing,

and analyzing phenomena found in the chosen text, in this case the in-depth interviews with my participants (Glaser & Strauss, 1967).

In addition to grounded theory and in order to further define the emerging categories, I made use of the following concepts:

- *Narrative analysis* (Gergen and Gergen, 1983; Sharf & Vanderford, 2003). As Gergen and Gergen argue (1983), individuals often use narratives in an attempt to reconstruct a sense of self; additionally, a narrative perspective “invokes two relevant contextual forms: the lived context of the events being retold and the living context of the telling itself” (Babrow, Kline, and Rawlins, 2005, p. 38); and
- *The conceptual framework of stigma* as described by Goffman (1963), who asserts that society stigmatizes certain health conditions or illnesses, impacting a person’s preferred identity, i.e. labeling an individual as not normal or not complete; and
- *The concept of coping with illness-related uncertainties* (Hines, 2001), which uses and extends problematic integration (PI) theory (Babrow, 1992; Babrow 1995; Babrow, 2001; Babrow et al., 2000) and related theories of uncertainty management in relation to communication. PI Theory discusses “the difficulties we experience when probabilistic and evaluative orientations to a particular object (e.g., person, event, idea) destabilize one another and unsettle such orientations to associated objects” (Babrow, 1995, p. 284) and starts from a perspective that every situation has an optimal level of uncertainty (a comfort

zone), which is sometimes higher and sometimes lower and we try to achieve and maintain that level of uncertainty (Babrow et al., 2000). Hines's (2001) concept of coping with illness-related uncertainties provides the following extensions on PI Theory:

(a) note[s] that theorizing must focus on multiple, interrelated uncertainties rather than a single such uncertainty; (b) explain[s] how communication with others often problematizes efforts to cope with illness-related uncertainties; and (c) identify[ies] specific factors that may influence how persons choose to cope with these uncertainties. (Hines, 2001)

3.2.3 Participants

In my research, which was conducted in the capital of Serbia, Belgrade (also the largest city in Serbia, with a population of about 1.2 million), during the period between May 2006 and July 2006, I interviewed sixteen (16) women and four (4) men of different social backgrounds, occupational status, and educational level, ages between thirty-four (34) and seventy-six (76). The original selection criteria included women who have had hysterectomies and, when possible, male partners of women interviewees. However, a great majority of male partners (12) of the female participants were not willing to take part in the research or the female participants were not comfortable with asking them to participate. For this reason, with such a small sample of male participants, the findings based on men's responses will not be included in this report.

Due to the social stigma and social disapproval of homosexuals, bisexuals, and lesbians still present in Serbia today, it was virtually impossible to recruit self-identified

lesbians and bisexual women who have undergone the hysterectomy procedure and who would be willing to participate in the study. As a result of these circumstances, only women who declared themselves to be heterosexual were interviewed. All the participants were of Serbian nationality with residence in Belgrade.

For additional information on participants' education level, social classes they belong to, relationship/marital status, the number of children they have, and reasons why they had a hysterectomy, please see Table 3, Table 4, Table 5, Table 6 and Table 7, respectively.

Table 3

Participants' education level

Education level	Number of participants
Elementary school education	3
High school education	8
College/university degree	3
Master's degree	2

Table 4

Social class⁸ participants belong to

Social class	Number of participants
Lower class	2
Upper-lower class	7
Lower-upper class	7

Table 5

Relationship/marital status

Relationship/marital status		Number of participants
Married		10
Unmarried	Not in a committed relationship	4
	In a committed relationship	2

Table 6

Number of children that participants have

Number of children	Number of participants
At least one child	13
Child-free	3

⁸ Social categories were determined based on the research conducted through multiphase random sample of 1,500 participants, which represent citizens of Serbia (without Kosovo) older than 18 years of age. There are four social classes determined: lower, upper-lower, lower-upper, and higher-upper class. This classification was made based on: a) material assets the individual possesses (apartment or a house, home appliances, car, cell phone, etc.); b) salary; c) assessment of one's own material situation; and d) scope of expenditures within the household. Determination of social classes was based on an empirical study, and the questionnaire used contained about twenty individual indicators based on which the participants were divided into the abovementioned categories. ("Bilten G17", G17 Institute, August-September 2004, year 5, number 52-53)

Table 7

Reasons for hysterectomy

Hysterectomy Reasons	Number of participants
Benign fibroid tumors, (which caused them pelvic, low back pain, and heavy or lengthy menstrual periods), endometriosis, or heavy or abnormal vaginal bleeding and other potentially pre-cancerous conditions	12
Treat cancer of the cervix, ovaries, or uterus (and had the organ(s) removed as part of their cancer treatment)	4

3.2.4 Recruitment Strategies

The process of recruiting participants was a painstaking, time-consuming one, since none of the physicians or hospitals I contacted were able to assist me in recruiting women for my study. The main reason for this is that both physicians with private practice and general or specialized hospitals in Serbia rarely, if at all, provide pre- or postoperative psychological counseling for women undergoing hysterectomy procedure, and there are virtually no support groups for hysterectomy patients existing in Serbia, which I could use as a recruiting source. Furthermore, research conducted by scholars not affiliated with official Serbian academic or governmental institutions is rarely, if ever, conducted in Serbia and since I, as an independent researcher from Texas A&M University, did not have the support of any governmental, medical, or academic entity in Serbia, I did not have access to recruiting strategies that are more commonly used in the United States. For these reasons, my participants were selected exclusively through local personal contacts in Serbia and a number of them included friends and family members.

With my initial contacts, I employed network or snowball sampling technique to recruit a larger pool of women from a variety of socio-demographic backgrounds.

3.2.5 Development of Interview Guide

As previously mentioned, my data collection method consisted of conducting in-depth interviews, all of which were conducted in the participants' native language, Serbian, and were audio-recorded and transcribed. The duration of the in-depth interviews was between one and two hours. The interviews were loosely structured and open-ended. Using probes and invitations to elaborate, I encouraged my participants to tell the story of their hysterectomy experience at length with few interruptions from me, so that the emerging narratives would be as natural as possible under the circumstances.. After I transcribed the interviews, I translated them from Serbian into English, which was rather difficult at times because some expressions and metaphors were literally impossible to translate, but I tried to make them as comprehensible as I could without taking away from the original way my participants framed their thoughts in their native language. There was no financial compensation for participation in the study. Interview locations were negotiated with individual interviewees for their convenience; in most cases, they took place in the participants' private residences, except for one interview which took place in my parent's home. The entire interview protocol, as well as the in-depth interview questions are attached as Appendix A.

3.2.6 Analysis of Interview Data

Data analysis involved reducing the collected data into smaller categories or patterns, which provide explanation for the data. In the first step of this process all the

recorded interviews were transcribed using a word processor and coded using category labels. During the first step, i.e. the open coding, the concepts or themes were identified and named. In the next step of the analysis, the coded data were segmented and divided into groups that shared similar themes or concepts, or the core categories. I discuss the major themes/categories that have emerged from the women's narratives and provide a detailed data analysis in the next chapter. The third and final step of data analysis involved summarizing and drawing conclusions based on the data. These conclusions are discussed in the Chapter V of this report.

CHAPTER IV

DATA ANALYSIS

Narrative expression is one of the main forms through which we identify, experience, and evaluate our actions and the value of our lives and the world that surrounds us (White 1980; Somers 1994; Ochs & Capps, 1996). Narrative sense-making enables individuals to cope with chaotic conditions such as chronic illness and disability (Sharf & Vanderford, 2003). As Weick (1995) affirms, storytelling is pivotal in the sense-making process, allowing individuals to cope with confusing, equivocal, and chaotic conditions of everyday life, including suffering and illness.

For the purpose of this analysis, it is helpful to consider hysterectomy as a disruption or a crisis in a women's life (Raphael 1978; Kaltreider et al., 1979). As Lalinec-Michaud and Engelsmann (1989) note, "[S]uch a crisis reverberates on many aspects (self-concept, sexual and marital adjustment, activities), and, as in any important crisis, the quality of support around the woman and the reaction of her environment is of crucial importance" (p. 169). I would add that yet another crucial element in the process of moderating the stress of this intervention is communication with others. As Babrow and colleagues (2005) assert, "[W]hen we no longer take for granted the well-being of our bodies and our worlds, communication with others is essential to ongoing meaning making" (p. 32). In-depth interviews with Serbian women who had hysterectomies and the stories they shared with me, which were, in some cases, voiced for the first time, while representing the key aspect of my study, hopefully served a more vital purpose

concurrently—that of helping my participants understand, make sense, and cope with their lived experience of hysterectomy through sharing their stories.

An exploration of my participants' narratives and my interpretations of gathered data shaped the emergent codes that eventually led to formulation of central theoretical concepts; in other words, the grounded theory process, starting a chain of theory development through initial or open coding; followed by line-by-line coding (examining each line of data and then defining events and actions embedded within it); identifying the major themes; memo writing and exploring the codes, which led to the first draft of the completed analysis (Charmaz, 2003). My analysis reveals how Serbian women make sense of their lived hysterectomy experience, examining five prominent themes: Serbian culture of imperative motherhood; the role of relational partners; women's health-related beliefs and practices; spirituality and religion in relation to hysterectomy experience; and the role of social networking. The rationale behind the way in which I ordered the prominent themes in my analysis is based on the frequency with which they appeared in women's narratives. For instance, motherhood appeared as a prominent theme in all the narratives, while the theme of social networking was directly addressed by three women only, although others made some brief reference to it in their stories as well. An explanation of each of these six prominent themes is presented below. Finally, I conclude the chapter by providing a short discussion of the strategies for overcoming the stigma associated with hysterectomy.

4.1 Serbian Culture of Imperative Motherhood

Motherhood in today's Serbia is situated in a specific cultural, social, and historical context and it manifests itself in what sociologist Marina Blagojevic refers to as *self-sacrificing micro matriarchy* (Blagojevic, 1997, p.163). The concept of self-sacrificing micro matriarchy implies that:

Families are becoming “mother centered” in the sense of driving force of family life, that there is a structure of authority that is hidden [...] but active, that members of a family have a large degree of dependence on women in satisfying essential nutritional and hygienic needs, that there is an inclination towards matrilineal kinship, and that there is emphasized ‘women’s politics of networking,’ that women actually achieve their domination, concentrate and even expand their power, through self-sacrifice [...] Self-sacrifice of women [in Serbia] is seen as specific women’s strategy to improve the individual position of women, to strengthen their self-confidence and to help them reconstruct their identity in period of ‘transition’. (Blagojevic, 1996, p. 636)

The ethics of self-sacrifice is deeply entrenched in the consciousness of women in Serbia. The model of self-sacrificing micro matriarchy in Serbia is confirmed by the high level of acceptance of the maxim: “Every normal woman should sacrifice for her children.” As many as 3/4 of Serbian women believe that mothers “should do everything for their children even if that means self-sacrifice,” while less than 1/4 consider that mothers “have a right to their own lives” (Blagojevic, 1996, pp. 641, 626). All women who participated in my study, with the exception of one participant who now resides in

the U.S., stated more than once during our interviews that “children are the meaning of life” and that not having children, particularly deciding voluntarily not to have them, indicates deviance and extreme selfishness in a woman and is considered to be a very negative, even unacceptable, life choice. This same statement (children being the meaning of life) is also restated in other (albeit quantitative) studies conducted in Serbia examining women’s parenthood patterns (Petrovic, 1994; Blagojevic, 1996), reflecting the most common attitude towards motherhood among female population in Serbia in general.

My participants’ stories of motherhood and its implications in their lives and the lives of Serbian women in general can be further identified as *stories as culturally informed constructs* (Mattingly, 1998; Williams, 1984; Bury, 1982),

4.1.1 Stories as Culturally Informed Constructs

As Williams (1984) and Bury (1982) argue, the self is not merely an embodied being, but a social being that interacts with others and exists within a certain socio-cultural sphere. The stories told and shared are not merely expressions of the body or cognitive endeavors to make sense of the world, but are imminently shaped by the social and cultural context in which they are created and expressed. Moreover, as Mattingly (1998) argues, referring to Garro (1992, 1994) and Holland & Kipnis (1994), cognitive anthropologists continue to examine stories “as places in which individuals are able to both give expression to an experience which is intensely personal and at the same time (or, as part of the same process) give a culturally informed meaning to their experience” (p. 14). In the following subsection I provide and discuss several examples of narratives

featuring culturally important components of womanhood in Serbia, primarily motherhood.

4.1.1.1 Motherhood as the Primary Component of Womanhood in Serbia

Being a woman in Serbia more often than not means being a mother, and a self-sacrificial one. One of my participants, Maja⁹ (age 55), in her discussion about the traditional view of women in Serbian society and what is expected of them, states:

Serbian women are primarily expected to be mothers. If not a mother to the children she will give birth to, than, in some way, a mother to her husband. A woman takes care of the basic needs related to home and family, because that is the traditional view of things, she takes care of the children if she has them, makes sure that they are fed, dressed, put to bed on time, taken care of when they're sick, but also, in that traditional sense, a woman takes care of her husband and maybe some other members of the family who happen to live in the same household. If a woman does not fulfill these 'duties,' it is considered that she did not fulfill her life purpose.

Maja goes on to talk about historical and social circumstances that affected the position of women in Serbian society and further complicated it:

During the fifty years of communism and socialism, a woman was also expected to fulfill her "social" role in order to satisfy the socialist requirement for gender equality which existed in theory, but that equality never really became reality because men did not take a part of women's duties onto themselves. Well, actually, I have to be fair here, not all men are like that, but most of them are. Women in Serbia today are expected to be mothers, to take care of their children, husband, and other family members, but also to work in an office and bring home the bacon, like I did for many years and still do, to cook, clean, and basically do everything a woman can do, all at once. To make things worse, a woman is not only torn by the family, society, and all these numerous tasks that she needs to perform, but she is also torn inside, by herself, because she at the same time feels obliged to do all these things but also something inside her tells her that she doesn't need to do that, that she should take care of herself for a change. This is a slightly schizophrenic situation, actually (laughs).

⁹ Maja had a hysterectomy eight years before the interview took place, when she was 47.

Furthermore, in the following excerpt, she discusses the importance of motherhood in Serbian culture and how it is essential for a Serbian woman to be a mother:

In Serbian culture motherhood is extremely important. That's apparent everywhere you go in Serbia. There are very few women, I can literally think of only one or two that I know, who didn't consider motherhood to be their primary goal in life. A part of that whole scheme is also marriage and all the other related stuff, while everything else is considered subordinate. I think that in a way our historical situation influenced all that—all the numerous wars we had on our territory and all the men that were killed in battles—all that in some way influenced the idea that the woman is the one who must prolong the life of the nation by bearing children.

To illustrate Maja's self-sacrificing mode of behavior, which in many ways corresponds to the mode of behavior of my other participants who experienced motherhood themselves, as well as the majority of Serbian women in general, I provide the following passage in which she talks about how she decided to have a partial instead of the total hysterectomy, mainly because she wanted to get out of the hospital as soon as possible and come home to take care of her children when they come back from their summer vacation, as well as her husband, whom, as she admits herself, she considers as her third child:

I had my operation in 1998. It was eight years ago, so I was 47 at the time. I had a partial hysterectomy, the upper part of my uterus was removed, but my cervix was left in place. They removed that part only because the doctors thought that the tumor didn't spread further and that there was no need for removing the cervix as well as uterus because that could lead to a premature menopause and cause some other health problems. But actually the choice about that was mine, so I chose the first option not because I was afraid of premature menopause, but because I wanted to leave the hospital as soon as possible and go home to be with my family—and that's the truth. If they removed the entire uterus I would have stayed in the hospital at least ten days longer and there is this postoperative recovery in that case and the woman cannot go back to her normal life so soon after such a radical intervention because it requires cutting into the abdomen and

my procedure was performed vaginally. [...] I could have had my entire uterus surgically removed and then I wouldn't have to worry about it any more, but it was more problematic for me to worry about my children missing me at home than my own issues, so I basically opted for the solution that would bring me back home to them more quickly.

As described in the passage, even though she was offered a clear choice, Maja did not think about what was best for her in the long run, but what was best for her family at that particular moment in time.

Another participant, Milena¹⁰ (age 47), states:

I think motherhood is very, very important. I tried my best to give as much love as possible to my children, and when I realized I won't live to get much respect from my husband, I decided to completely dedicate myself to my children [sons] and, [...] and make sure they don't grow up to be like their father. I put a lot of effort into that. I would always support my sons. [...] I sacrificed my marriage and my private life consciously, for the sake of my children. But that's what women are supposed to do, right? I didn't want to divorce my husband because then I wouldn't get to be with my children—and what would that do to my family? So I blocked my feelings [um] because the children are my focus [...] they are my center. I literally forgot about me. [...] But I don't regret it.

Women who are mothers, like Maja and Milena, seem to be aware of the sacrifice they are making for their children and their families and it makes them feel reassured that they are doing the right thing since that is the most widely accepted mode of female behavior in Serbian society. Although most women in my sample tend to think that motherhood is a “great responsibility” (Vera¹¹, age 48) and “every woman's duty” (Divna¹², age 60), they also seem to think that “women who don't want to be mothers are very selfish and only think about themselves” (Ivanka¹³, age 56), that they should be

¹⁰ Milena had a hysterectomy three years before the interview, when she was 44.

¹¹ Vera had a hysterectomy five years before the interview, when she was 43.

¹² Divna had a hysterectomy seventeen years before the interview, when she was 43.

¹³ Ivanka had her hysterectomy four years before the interview, when she was 52.

happy with their lot and should “have no regrets” (Milena), otherwise they are “ungrateful and spoiled” (Ivanka).

As can be observed from the above quoted passages and interview fragments, the narrators may be at the center stage of their stories, but they cannot disentangle themselves from the broader spheres of social and cultural interaction. While they may contribute to those spheres through their narrative, they are also, in turn, shaped by it. Exploration of narratives such as these informs us about the cultural practices and assumptions that infuse the society we live in, as well as permeate our very identities.

4.1.1.2 Issues of Sterility and Childlessness

In Serbia, as in other highly pronatalist societies, childlessness, even when it is involuntary, tends to be treated as a form of social deviance. Since motherhood is typically synonymous with femininity, childless women are “deprived of the most central element of their gender identity, and, hence, personal integrity” (Remennick, 2000, p. 822; also Miall, 1986; Stanworth, 1987; Whiteford & Gonzales, 1995). Serbian society is family-oriented and openly pronatalist, which is reflected both on the institutional and personal level. Furthermore, as Blagojevic (1996) states:

In the whole of ex-Yugoslavia, including Serbia, there was a general high acceptance of marriage. There was also a relatively high stability of marriage, measure by divorce rates. This could be explained, on the one hand, by traditional factors (an agrarian society) and, on the other hand, by cohabitation and the private domain being generally extremely important for fulfilling the existential needs of people, especially in the situation of low standard of living

and inadequate organization of the public sphere (service sector, especially). (p. 629)

Additionally, women's everyday lives in Serbia are strongly focused on parenting (Blagojevic, 1996). In this social climate motherhood is regarded as mandatory, and married women with no children of their own are considered unlucky, morbid, or even deviant (Portugese, 1998).

In this vein, one of my respondents, Maja, states:

In Serbia it is commonly accepted that a woman absolutely must have a child, and not just one child but more than one in order to keep the nation alive. And if a woman doesn't have children—in that case most women have an extremely hard life. If they are not forced to deal with the pressure of those around them, than they have to deal with their own, inner pressure and regret—the feeling that they did not fulfill their mission in life, that they are useless, in a way. Also, in most cases, it is inconceivable for a woman to not want to have children—she is considered extremely selfish if she doesn't want to have children and if she can't have them, then she is considered to be wretched, miserable, punished by God. That's the traditional view of things, which continues to live on even today. It's either that a woman imposes these ideas onto herself, or the society and people around her impose them onto her. There's always at least one person in her family or somebody close to the family who does that.

Some of the women's stories included accounts of mental disorders, high levels of depression, and even suicidal thoughts following the diagnosis of sterility in Serbian women. An illustration of these troubling stories is that of my mother's aunt who was confined to a mental institution following her hysterectomy and her husband's abandonment due to her sterility. The generally highly negative reactions to sterility tend to be even more pronounced in the cases of women who are married and therefore expected to become mothers, primarily by their husband, and then by the other members of their immediate family. It is considered very shameful for a man not to be able to

have children, so even in the cases of male sterility, women are the ones publicly taking the blame for the couple's childlessness. In the case of marital sterility, i.e. when it is not clear whether the husband or the wife is the one with fertility problems, the woman is usually blamed in advance, automatically, and the marriage often falls apart whether she wants to end it or not (Tripkovic, 1997).

Nina¹⁴ (age 35), who is a medical doctor in general practice and a very well educated person, took her loss of childbearing ability following her hysterectomy very tragically. She was unable to leave the house for two months after the procedure and felt it was necessary for her to end her six year long relationship with her fiancé (their wedding date was already scheduled) because she was “no longer able to give him children. And he deserves to have children.” Even though her fiancé desperately tried to convince her that he loved her and did not mind that she became sterile, Nina would not accept his arguments:

I told him: “Yes, sure, this is what you're saying now, while we are still not married and you feel there are all these more important things in life, like love, but in two, three, five years, what will you think then? When all your friends have children and take them out for a walk in the park, and the neighbors ask you when are we going to have a baby, what then? And what will your parents tell their friends and relatives, why they still don't have grandchildren? Who wants a daughter-in-law that's faulty? Who wants a wife that's faulty?” [...] He didn't say anything, he just kept silent. I knew he thought the same thing, he just didn't want to say it out loud. So I said it for him. [...] I said it for him.

¹⁴ Nina had a hysterectomy two years before the interview, when she was 33.

Another participant, Jagoda (age 38)¹⁵, a woman abandoned by her boyfriend of six years following her hysterectomy and her diagnosis of sterility, shares her feelings on the subject by stating:

If you can't give birth, then you barren, you are dry. You are not a woman. Woman is a mother. So no man wants you. [...] And who can blame him? You are nothing to him if you can't give him a child, a son to continue his family name. So he leaves you for a younger one and he makes her a child. And you are left alone and no one wants you. Hell, you don't want you! 'Cause what are you? Nothing! (raises her voice) [...] I'm on medications now, pretty much all the time. That's the only way I can stand it without ending it all.

In Serbia, both men and women in the past, as well as now, define parenthood as “the meaning of their life” (Blagojevic, 1989; Petrovic, 1994; Blagojevic, 1996). The tragedy of Serbian women who are unable to have children and have therefore lost the core of their being, is sometimes too deep to be voiced. Oftentimes it is manifested in a deep feeling of loss and emptiness that cannot be alleviated easily; that sometimes requires years of treatment and recuperation, and frequently cannot be resolved in spite of all the effort put into it, for the woman is constantly reminded of her ‘inadequacy’ and “complete uselessness” (Jagoda) by others as well as herself.

4.1.1.3 Inability To Bear More Children

In addition to problems voiced by women with no children during the in-depth interviews, there were also those raised by women who are already mothers but wish they had more children. In some cases this situation seemed to be quite problematic, as women were voicing their regret over not having more children in addition to the existing ones not only because they enjoy being mothers, but also because they feel

¹⁵ Jagoda had her hysterectomy one and half years before the interview, when she was 36.

motherhood and reproductive ability are an important part of who they are as women and an integral part of their personal identity. In some cases this situation was further problematized because women had only daughters and wanted to have sons who would continue the family name. Vesna¹⁶ (age 40) gives her personal view of this issue:

We have a wonderful daughter and we love her very much. But my husband always wanted a son. He's very attached to his family heritage and he always said he wanted a son, and [um] he would name him after his father. I know it's silly, but now I worry that he might leave me because [um] they took it all out, you know and [...] I can't have any more children and we don't have a son. [...] But we never talked about it, 'cause he doesn't really talk much anyway and I don't want to bring that issue up. It's better this way, you know what I'm saying? [laughs nervously]

In other cases, women already had sons, but wanted daughters who would “support me and understand how I feel as a woman” (Milena).

Milena goes on to say:

I just wanted a little daughter, you know. To cuddle with her and dress her up nicely. Don't get me wrong, I [...] I love my sons, I would give my life for them but [...] men can never understand you like a woman can, right?[...] and [...] a little girl, that would have been nice. Really nice, you know? [starts crying].

Loss of childbearing potential can represent a problematic issue even for women long past childbearing age. Another participant, Ana¹⁷ (age 52) shares her sorrow over the loss of her womb and for not being able to have more children following a hysterectomy:

Having a baby, a child, that's the most wonderful thing in the world. If you don't have a child you cannot imagine how amazing and wonderful that experience is. So [...] I became pregnant three months into my marriage and I have a son now. But unfortunately, when I became pregnant again, I regrettably [...] it is a sin against God, I know but [...] I had an abortion. My husband wanted that child,

¹⁶ Vesna had a hysterectomy three years before the interview, when she was 37.

¹⁷ Ana had a hysterectomy five months before the interview, when she was 51.

but I, for some reason [...] I wanted my first child so much, but this one, I don't know, I just couldn't stand it [...] I just wanted it out. When I think about it now, I guess I had to be punished in life too, like others are. Had to be a sinner. That's a terrible sin. Now when I think about it, it's a mortal sin. But it probably had to be like that. I had a feeling like [...] like there was a foreign body in my organism and I had to take it out. No, and no, and no. I just couldn't stand it psychologically. [...] My first delivery was very, very painful. They cut me up like a cow, so that was a great trauma for me. And I told my husband: I will never have a child again. The pain [...] it was unbearable. But [...] I adore my son; not that I love him, I adore him. That is the most wonderful feeling in the world. So the loss of my uterus [...] something strange happens when they take it out [um] [...] I even thought at one point: Is it possible they took out my womb, where my son used to be? I gave him life in that womb. That [...] that made me very depressed. I am so sorry I didn't have more children. A woman should have at least three [...] at least three. My son asked me for a brother or a sister when he was small, but I wouldn't do it. I regret it now [...] very much. Now I say to my husband sometimes, why don't we adopt a child? But no, no [...] I don't think I could ever love an adopted child as much as I love my own. My own flesh and blood [...] And when the pains from the operation subdued I was very, very sad that it had to happen to me. I am not a woman anymore—what am I now? I know that my womb cannot serve a reproductive purpose anymore because I'm passed that age, but to know that I can never [...] I can never even dream of having a child again [...] That was devastating.

In 1995, in the region of Central Serbia and Serbian province of Vojvodina, a large quantitative study was conducted on parenthood issues among women, which surveyed 800 female participants (Blagojevic, 1996). Only 9.3% of the participants agreed with the statement: “Children bind parents,” while 2/3 of women surveyed agreed with the statement that, “Every normal woman should sacrifice herself for her children.” Moreover, as many as 3/4 of women considered that “mothers should do everything for their children even if it means self-sacrifice,” and only 23% felt that “mothers have a right to their own lives” (Blagojevic, 1996). With these findings in mind, it is no wonder that in spite of many obstacles, women in Serbia tend to want more children. This feeling may be increased by the fact that after a total hysterectomy they cannot have

children any more and that sense of finality and conclusiveness makes them regret the lost chance which will never offer itself again. Additionally, they may desire more children because having them could make them feel more understood, supported, and loved, especially in the case of women without daughters, while not having them can create problems with their husbands or other members of their immediate family, especially in the case of sons who are, in a patrilineal¹⁸ society like Serbian, supposed to continue the family name.

4.1.1.4 Adoption and Other Alternative Ways of Performing Non-biological Motherhood

Adoption is a humane and practical alternative to biological parenthood and “as a method of acquiring children [...] has a long and fairly reputable past” (Spar, 2006, p. 162). As Spar (2006) further states, “Historically, [adoption] was the only means by which infertile couples could obtain children, the way for them to salve unmet desires and preserve social goals” (p. 162). In countries such as U.S., adoption is widely accepted; however, the situation with adoption in Serbia is different—the option of adopting a child is rather complicated and lengthy, mainly due to the administrative issues¹⁹, but more importantly, it is not very popular. Even though the number of couples and individuals in Serbia who are deciding to adopt a child is increasing, the predominant attitude towards adoption is still negative. Similar to other countries with a strong patriarchal culture, both men and women in Serbia are resolute in becoming

¹⁸ Relating to, based on, or tracing ancestral descent through the paternal line.

¹⁹ However, in May 2006 a unique adoption registrar has been established in Serbia by the Ministry of Labor and Social Politics, which should significantly facilitate adoption process in the future.

biological parents, explaining this determination principally by the desire for genetic continuity and continuing the family name.

Even though a specific question related to adoption was not originally envisioned within my study protocol, this issue did come up in my interviews with female respondents. Most respondents in my study were clear that, when they were referring to children they would want to have, they meant their own biological children, and, more importantly, biological children of their husbands or male life partners. According to my findings, women did not really mind not having their own biological children but were afraid that their male partners would resent the idea of adoption. As Jagoda states in her discussion of why she never suggested the option of adoption to her boyfriend who abandoned her due to her hysterectomy-induced sterility:

Why would he want to adopt a child? He's not crazy to do that—bring up somebody else's child. That child wouldn't be his, of his own blood. And if there were anything wrong with the child, then he would blame me! Because I'm the barren one, not him. He can have children of his own. I can't. So why would he ever want to do it?

Only two out of sixteen respondents stated that they would seriously consider adoption as an option. One of them actually adopted a child, but only because her husband could not have a child of his own due to his own sterility. For that reason she decided to adopt a male child, even though she had a daughter from her first marriage, so that her second husband (whom she divorced in the mean time) “would have a son, an heir” (Rada²⁰, age 48). Rada's first marriage lasted for three years only, after which she

²⁰ Rada had a hysterectomy thirteen years before the interview, when she was 35.

ran away from her abusive husband who used to beat her on regular basis. Rada shares the story of her second marriage and the adoption of her son:

I always thought I would never get married again but I did when I was 35. I met my second husband in March and had my first surgery in April, because I had two surgeries, and he took me to the hospital after my cyst broke, and I had high fever, and an infection, and was in a lot of pain, and he took me to see a doctor. [...] I am still grateful to him, because he kind of saved my life back then [...] because his sister is a nurse and she said he should urgently take me to the hospital. And they removed my left ovary [...] that was my first surgery. And he took me to his home and took good care of me while I was sick and so I decided to marry him, even though I was his third wife. His previous marriages were unsuccessful, I guess because they couldn't have children. So he won my heart and I agreed to marry. But he was an alcoholic and I didn't know that when we met, because he wasn't drinking at first but then he started again. I didn't realize it before, he was hiding it. So I wanted him to be treated for alcoholism. He told me he wanted to have a child because he didn't have children of his own and that it would help him pull through and stop drinking. So we decided [...] you know, he didn't drink all the time, sometimes for months and he was a totally different person then [...] so we decided we should adopt a child. And we were lucky to find a child very soon and after that he went for a treatment for alcoholism and he stopped drinking. And he still doesn't drink, as far as I know. But two years ago he suddenly fell in love with a woman from Ukraine and he just left me a letter about it and left me [...] and now he lives in Riga, in Ukraine [...] with her. And I live with our son, we adopted him when he was three and half years old and he knows he was adopted. He is twelve now. We adopted my son one year after my hysterectomy. I always wanted to have a lot of children, so I had a need to [...] to have that experience again. And also it was important to my ex husband, he really wanted it. So we did it. And now I am very happy we did!
[laughs happily]

Even though Rada essentially decided to go through the adoption process for the sake of her husband who could not have biological offspring, she is very pleased with her decision and very happy with her life with her adopted son. She feels more complete as a person and as a woman because of this decision.

Other ways of reframing motherhood besides adoption may include mothering of other people's children, like in the case of my mother's aunt Milka who was happy to

accept her husband's illegitimate son and raise him as her own, which finally helped her overcome her great sorrow over not being able to have children of her biological children. There are also other paths to becoming nurturers that women with hysterectomies may chose. Another respondent, Tamara²¹ (age 34), in our second interview reports:

You remember I told you about a year ago that I thought one of my ovaries was still functioning? Well, it turns out it's not, apparently due to chemo. So the IVF²² and surrogacy options we talked about before are out of the question. But you know what? I actually feel good about it, because I finally feel like I don't *have to* be a mother like everyone kept telling me before. [...] Because I never felt I was really cut out for it, but people kept pressuring me in Serbia and [...] Now that I live in the U.S. things have changed a lot, because I'm in a different environment and all that pressure is gone [...] I'm not sure why exactly. I still feel like it would be hard to get seriously involved with a guy, 'cause he'll probably want to have kids and I can't have them, but [...] you never know. Maybe he'll already have kids of his own or we can adopt a kid—that would be really nice, I would like to make a kid happy, you know. But the point is, I no longer feel pressured to be a mother, which is good 'cause I don't know how to be one, and I'm not really a motherly type anyway [laughs]. Seriously, I never really wanted to have kids anyway but when I learned I couldn't I was sad about it because I thought that was something every woman absolutely *had* to do in her life. But I don't think that any more. I think there are different ways in life for a woman to be a nurturer if she wants that. Whenever I go back to Belgrade I spend a lot of time with my brother's kid and I send him all these gifts and spoil him rotten—he's such a cool kid, you know, and I get to enjoy all that good stuff without ever having to change a single dirty diaper, you know [laughs]. And [...] I love my friend's little daughter, she's so cute [...] I [...] I buy little presents for her and I took like a million photos of her [...] it feels great spending time with her without all the crazy responsibilities. She's so happy to see me when I come to visit, and that's really what I always wanted. When she's a teenager and when her parents drive her crazy she'll come and crash with her cool aunty Tamara,

²¹ Tamara had a hysterectomy four months before our first interview, when she was 33. Our second interview took place one year after the first, when she was 35. She was the only respondent I had two interviews with because she was the only one I interviewed almost immediately after her hysterectomy. For that reason I thought it would be valuable to interview her again one year after our first conversation and to compare her responses given during those two interviews. My results have show that her views, especially those on motherhood, did change.

²² *In vitro* fertilization (IVF) is a technique in which egg cells are fertilized by sperm outside the woman's womb.

and I'll help her get over her adolescent neurosis, you know [laughs]. So that's what I really always wanted to be—a cool auntie.

Tamara has found a way to reconstruct her identity outside the traditional motherhood scheme. Even though there are questions she continues to ask, she feels that her life has not been “ruined” at all by her experience of hysterectomy and her subsequent sterility, but that she has, in fact, come closer to her “true identity,” that of an occasional nurturer, which fits her personality better than the notion of self-sacrificial motherhood she has never identified herself with. Tamara has managed to successfully reframe the concept of motherhood because not all mothers are or have to be biological mothers.

4.2 The Role of Relational Partners

Health care narratives are implicitly relational (Beck, 2005) and “[a]lthough health care narratives may stem from an individual’s experience with disease or disability, that individual cannot construct the narrative in isolation; others inherently (even if inadvertently or unintentionally) contribute to the emergent, temporal enactment of health narratives, and as such, those narratives constitute relational constructions” (p. 64).

Relationships with intimate partners are very important for personal identity and sense of self since “the opinions of those people who matter most to us—whose opinion we care about greatly [...] have a stronger effect on our self-concepts than the views of those to whom we are indifferent” (Rosenberg 1981, p. 98).

The results of my study reiterate the findings of previous studies, such as those conducted by Bernhard (1992), Smith and Reilly (1994), Elson (2004), etc., which demonstrate that male partners’ and/or husbands’ reactions to women’s hysterectomies

play an important, even pivotal, role in the women's emotional recuperation and their ability to reclaim or preserve their gender identities after the hysterectomy.

4.2.1 The Relationship Between Sexuality, Body Image, and Gender Identity

Expressing one's sexuality in Serbia can be somewhat problematic. I have already discussed the public odium towards homosexuals, lesbians, and bisexuals in Serbia, who are in most cases forced to conceal their sexual identity in public. In addition to that, open expression of one's sexuality in Serbia, even in the case of socially accepted heterosexuality, can be considered shameful. As Tripkovic (1997) observes:

Taboos in the traditional culture of the Serbs express contempt and resentment towards sexuality. Through marital rules, sexuality is kept within the boundaries of acceptable behavior. Sexuality per se, within marriage and even more so sexuality that breaks established rules, is considered unseemly, because it can cause disorder and violence. Women are to hide the signs of their sexuality. (p. 188)

This kind of cultural climate problematizes the situation of women with hysterectomies even further, because they may feel even more "unseemly" or "improper" in the sexual sense, because of the changes in their body image. This state of the affairs can further increase the discomfort and uneasiness with their own bodies that women who have had hysterectomies are likely to experience. Furthermore, as reported in Chapter II of this report, sexuality in Serbia is closely related to fertility and the lack of childbearing ability can make women feel even less sexual.

As Elson (2004) reports, “While some research concludes that women suffer the loss of sexual desire and the ability to enjoy sexual relations following hysterectomy, other studies find that the reverse is true, and still others report no changes” (p. 124). Even though it is hard to generalize women’s sexual satisfaction and desire following hysterectomy, as each individual woman has her own, subjective perception of her own sexuality, which is evident in my respondents’ narratives, women in my study can still be divided into three categories depending on their overall satisfaction with their sex life following hysterectomy: those who feel nothing has changed; those who report deterioration of their sexual satisfaction; and those who report greater sexual satisfaction after hysterectomy.

4.2.1.1 Women Who Feel Nothing Has Changed

For several respondents in my study, in spite of the initial anxiety preceding reestablishment of sexual relations with their partners following hysterectomy, nothing really changed and they reported the same or similar amount of satisfaction with their sex life.

As Marina²³ (age 45) states, she was very frightened at first, but that in the end she did not feel a difference between her sexual satisfaction preceding and following the hysterectomy:

When I came out of the hospital, I thought how it’s gonna be when I go to bed with my husband again. Will it be the same? Will I be able to feel anything? What if I don’t? What if it hurts? I was terrified. So we waited for a couple of months before we did it. And in the end it was really OK. No change for me—it was all in my head. And my husband says he doesn’t feel any difference either.

²³ Marina had a hysterectomy two years before the interview took place, when she was 43.

But he's a guy, you know? He doesn't complain as long as he's getting some [laughs heartily].

Jelena (age 76) who was 49 at the time of her hysterectomy stated that as far as she was concerned, "there was no change whatsoever" and that her level of sexual satisfaction did not change after the surgery. Vera (age 48) also reported that in the sexual sense nothing changed for either her or her husband.

4.2.1.2 Women Who Reported Deterioration of Their Sexual Satisfaction

While for some women there was no change in the quality of sexual intercourse following hysterectomy, some other women, like Branka (age 51), Ivanka (age 56), and Milena (age 47) reported deterioration of their sexual satisfaction. "It all felt dry down there, like dusted with gunpowder. It hurt a lot," reports Branka. "I was very much into all that stuff before [the hysterectomy] but now I really don't feel anything anymore," states Ivanka. Another participant, Milena, reports:

I tried to have an intercourse with my husband two months after my surgery but my vagina was so dry I just couldn't stand it. So [...] So he got mad with me, said he waited long enough, and said I was faulty. [...] Damaged goods. That's what he called me, after seventeen years of marriage [wipes her eyes with the back of her hand].

One of the participants, Tamara (age 34), was very concerned that both her and her potential sexual partner(s) (she was not involved with anyone immediately preceding or following her hysterectomy) will be dissatisfied with the quality of sexual intercourse. As Tamara reported during the first of our two interviews²⁴, it was very difficult for her to engage in sexual relations with a man following the procedure since she felt unattractive, different, and was very uncomfortable with her own body and with telling

²⁴ The interview in question took place four months after Tamara's hysterectomy.

her potential partners about her health condition. Furthermore, she was very afraid that her potential sexual partner “would certainly be able to tell that I don’t have anything in there, I mean no uterus, even though I don’t think a guy would know what that means, since men are mostly ignorant about stuff like that, like exact female anatomy and such.”

In the following narrative Tamara shares her many fears and anxieties:

I really hate that I have a scar on my stomach, which is the consequence of the abdominal hysterectomy. It’s so [...] ugly. And so I feel ugly too. I mean [...] what will a guy think when he sees my scar? I don’t even know what I would say if he asked me what it was [...] appendicitis? [laughs] It’s on the wrong side though, but that’s just a minor detail, right? [laughs]. But seriously, I feel very uncomfortable with this issue. And also, I don’t know how I will react sexually. Will I be able to [...] you know [...] feel the same way I used to? What if it hurts me? What if he hates it? What if I hate it? I don’t know [...] there are all these questions that I don’t know an answer to and I’m afraid to learn the answer, you know? But I don’t really have a guy in my life now so [...]

Oftentimes women are not only unsure whether they will be able to enjoy sexual relations following hysterectomy but they are even afraid to try. As Tamara states:

I already feel pretty bad about myself as it is. What if I hook up with a guy and take my clothes off and he sees my scars and like [...] runs away, or something? How would that make me feel really? Maybe it’s better not to even go there, you know what I mean? And, on the other hand, what if I never get to be with a guy again? I’ll get to have the cobwebs down there and all that stuff [laughs] [...] But really, I mean, who would ever get serious with me anyway? What if he wants children? That’s very normal, I guess, to want to have children. And I can’t have them, so how can it ever get serious?

4.2.1.3 Women Who Reported Improvement in Their Sexual Satisfaction

Several participants in my study reported greater sexual satisfaction after hysterectomy. Vera (age 48) shared that her sex life with her husband was “even better than before, probably because now we are more relaxed because we don’t have to worry I’ll get pregnant.” Rada (age 48) reported that she enjoyed sex more after the surgery

because “there was no more pain. They removed those awful cysts, thank God! It used to hurt me so much, but after the hysterectomy the pain was finally gone. So everything felt much better.”

Ana (age 52), one of the few participants who was willing to share more details of her sexual life following hysterectomy, reported significant improvement in her sexual pleasure, even though she “liked sex very much even before the surgery.” In relation to this, Ana states:

My husband was so sweet to me. So loving and patient. He never once pushed me into anything I didn't want and it really meant a lot to me. It took a little while, about two months because at first we were both a little panicky, you know, a little scared. So we used all kinds of lubricants and stuff, both for him and me, but we did all that in a humorous kind of way, laughing about it all, together. So it was much easier that way: I would daub this special oil onto the head of his penis and he would use another kind of oil to lubricate my vagina, so we kind of tried to spice it up a bit, you know. It was all sort of kinkier and sexier than it used to be and I really liked it. He loved it too, sure! [laughs]. But in the beginning we were really scared and I told him right before we did it for the first time after the surgery: “I'm not sure if I'll be able to do this; brace yourself for the possibility that I won't be able to do it.” So he had to get himself ready for that possibility. [...] When we did it, it was like we were doing it for the first time ever. And it was amazing. We both felt that way. And now it's all so relaxed, as if we were transported back to the very beginning of our relationship. There's all this passion and heat, you know, but now we don't have to worry I'll get pregnant! [laughs]. So it's really good. So much better, actually. [laughs]

As previously stated, unlike Ana, most women didn't feel comfortable openly talking about sex and sexuality-related issues, and were not willing to provide details of their sexual experiences following hysterectomy, most probably due to the cultural taboos discussed earlier in this report. However, they all did report their general impressions about the quality of their sex life following surgery, which was, for some of them, the first time they shared these impressions with anyone.

4.2.2 The Quality of Partner Communication and The Importance of Partner's Support and Acceptance

As Darling and McKoy Smith (1993) point out, “on the surface a hysterectomy may appear to be a biological event for a woman, but it is also a psychological event for the woman, couple, and family, which can result in both sexual and relational changes.” What greatly determines the type and the nature of women's reaction to hysterectomy is certainly the reaction of their relational partners.

4.2.2.1 Rejecting Partners

Charmaz (1994) asserts that certain medical conditions can be damaging to intimate relationships. She further affirms that: “Perhaps the most telling moments and dramatic turning points occur in interaction with others. Ill people can find themselves being betrayed, stigmatized, exploited, and demeaned [...] Shock follows such an incident since the nasty surprise uproots one's take-for-granted assumptions about oneself, relationships, and social location (Charmaz, 1994, p. 235).

Some of the participants in my study shared stories of almost tragic lack of support from their relational partners. Milena (age 47) reported that her husband threatened that he would have sex with another woman because she was “sick and defective” and he did not want to “sleep with a sick and defective woman.” In the case of Jagoda (age 38), her boyfriend's rejection led to very serious psychological problems:

He wouldn't touch me, he wouldn't look at me. He kept telling me that I was empty and that he couldn't touch me [aaaah] any more. He wouldn't talk to me and he wouldn't come to my apartment any more. When I learned he had another woman, I started hearing these voices, I was hearing my uterus speak to me. It

had a mouth, and it kept talking to me, all kinds of stuff. About him and her. About me and how I shouldn't have done it [should not have agreed to a hysterectomy]. I cried day and night. [...] My sister came and took me to see a doctor, who gave me medications. I am much better now, but sometimes [...] sometimes I hear those voices again.

As Beba (age 40), an unmarried mother with one child, states:

After I had my hysterectomy, my boyfriend²⁵ seemed to be distanced from me and our lovemaking was much less frequent. I am not sure why, but I thought he was afraid to hurt me. But maybe that's what I want to think, because what if he was just disgusted by me [...] by my body and scars and all, you know? So [...] yeah [...] I started avoiding him too, sexually. I was so ashamed of myself. Now, things are better, but not much. It's not like it used to be before the surgery, for me. [...] I feel bad when I take my clothes off because I always think that he doesn't like me any more because of all that and [...] and also because I gained all this weight [slaps her thighs].

Divna (age 60), who was 43 at the time of her surgery, shared her experience with her husband following her hysterectomy:

He heard other women say about me that they [doctors] took everything out. So [aaah] so he wouldn't touch me with a stick He said: "You are all empty now, so what is there for me to do? I am a man, I need a woman." I was still his wife but I also wasn't his wife anymore [...] A real man needs a real woman and he didn't think I was a real woman anymore.

Some male partners, like in Divna's case, may perceive gynecological surgery their female partners go through as a loss of womanhood, which, simultaneously, represents an assault on their masculinity, which may, in turn, seriously jeopardize women's sense of self worth. Such rejecting partners are, unfortunately, more often than not "detrimental to women's confidence in their [own] ability to maintain or reclaim their gender identity" (Elson, 2004, p. 170).

²⁵ He is also the father of their child, and they live together but are not married.

4.2.2.2 Supportive and Caring Partners

Charmaz (1983) asserts that support from a relational partner, especially in the case of identity-altering illness, can help a great deal “to restore a floundering prior self” (p. 181). Elson’s research (2004) shows that support of relational partners helped women in her study “sustain or recover their sense of themselves as whole women” (p. 165). Finally, Goffmann (1963) contends that relational partners can play the role of the “protective circle” (p. 97), which is particularly important in cultures like Serbian, in which women who have undergone hysterectomies are potentially seen as deviant.

Vera (age 48) talks about the negative attitudes towards women with hysterectomies in Serbia and how support of her intimate partner helped her see herself in a different light:

Right after the surgery I wasn’t aware of what really happened to my body and after a while I didn’t even dare to think about it. We have learned, women from Serbia, I mean, especially my generation, to suppress all those feelings [um] to keep them all inside. I felt like I was totally suffocated in that sense, that I couldn’t give birth any more. But my sex life with my husband was great, you know, nothing really changed there, it even got better because the fibroids were gone and [...] it was just more relaxed but [...] I knew that people were feeling sorry for him [um], you know, that’s just the way people are here, that’s all ignorance [um] and people here tend to say: “Look at her, she’s no longer a woman. Her poor husband!” That was very disappointing for me and I [...] my husband, he knew it was all OK, that it’s all normal, even though my uterus and ovaries were gone, but in the company I used to work before my surgery, I remember [...] two [...] two of my colleagues, they were talking, and one of them was talking about his mistress and how he stopped seeing her after she had a hysterectomy and he used all these ugly, really derogative terms for her and [...] it was horrible for me to hear all that and [um] he said, to hell with her, she [aaah] she doesn’t have [...] doesn’t have [um] she’s like deflated, empty, you know, and [...] he didn’t want to have sex with her any more ‘cause she was no longer a woman. So I know that many men think, oh, it’s all over now, no more sex with this one, so I influenced my husband in that sense before, as if I knew it would happen to me [laughs], to prepare him, you know, so [...] I told him that all that is normal, that it all has nothing to do with the quality of sexual life, so he

was prepared [...] but I know that most men felt sorry for him because they think he doesn't have a woman in his bed anymore. So it made me feel really bad at first. But now I don't really care about other people, because my husband doesn't care. He doesn't see me in that way. For him, I'm still me.

As previously stated, Ana (age 52) reported that her husband was "so sweet" to her. She also reported that he was "So loving and patient. He never once pushed me into anything I didn't want and it really meant a lot to me." This obviously had a positive influence on her overall sense of self, especially since she had some psychological problems following her hysterectomy and was feeling depressed over her guilt for having an abortion in her younger years. However, her husband's support and love helped her overcome these obstacles and negative feelings, and it had an overtly positive effect on their sex life as well.

As Elson (2004) states, for some of her respondents, "support from intimate partners also made "all the difference in the world" in their efforts to maintain or reclaim gender identity following gynecological surgery" (p. 167). Jelena's²⁶ (age 76) story of her exceptionally satisfying and harmonious relationship with her husband, which seems to be quite rare in Serbia, restates that conclusion:

I didn't feel different after my hysterectomy at all, both physically and mentally. I know this procedure is very difficult for some women because I have friends who have been through a great turmoil, but for me [...] it was like [...] like going to a dentist and pulling out a tooth. I think that, even though my entire family was very supportive, the most important thing was my husband's complete support and love. I tell you, believe me, knowing the cases of my [um] fellow sufferers [laughs], I [...] I never for once felt jeopardized. I remember, afterwards, my son's friend's mother was in a similar situation health wise, and was supposed to have a hysterectomy [and] she is younger than I, so [...] she was concerned whether she would feel the same way, sexually, and whether her

²⁶ Jelena had a hysterectomy twenty-seven years before the interview took place, when she was 49.

sexual life will lose some of its quality. I assured her that, as far as I was concerned, there was no change whatsoever. [...] I am a very strong person, both physically and mentally, but I think that my husband's attitude towards me was probably the most important factor in my overall satisfaction after the procedure. We have been married for 53 years and just the other day we were talking about how that was an absolutely wonderful period of our lives, the period we have spent together. There were no excursions outside the marriage, like there often are [laughs]. We really understand each other and my husband is a very calm, serene person, and that is very important to me, because sometimes I tend to be a bit nervous myself. He calms me down. We talk about everything and I participate in his work a lot—he is an architect and an artist, and he is also musically inclined, just like me. I am assured of his love every day [...] and, of course, his respect for me. And that really [...] that really means a world to me.

In conclusion, as based on my findings, support, encouragement, and loyalty of relational partners in the face of a potentially highly emotional event in a woman's life such as hysterectomy can notably aid a woman in sustaining or recovering her sense of self and female identity, and speed up her emotional recovery following hysterectomy.

4.3 Women's Health Beliefs and Practices

Serbian women pay little attention to their own basic health care. Almost half of the women go to see the physician only when they are ill, and never for preventive purposes. Only one quarter of the women have regular gynecological health checks, while 35% of women almost never have any medical check-ups. Furthermore, despite potential future risks, almost 50% of Serbian women leave school due to family reasons, i.e., marriage or childbirth (The Belgrade Centre for Human Rights, 1999), so their lack of basic education may lead to less awareness about the importance of regular health check-ups and preventive medicine, especially when it comes to gynecological health problems which may, when untreated, lead to more serious health issues. Even though a specific question about women's health beliefs and practices was not included in the

interview protocol, issues related to this topic emerged in respondents' narratives, so I consider it important to report these unanticipated results. This section explores women's own health needs versus the health needs of others; gynecological health screening practices and access to health education (including the importance of doctor-patient communication); and coping with health-related uncertainties.

4.3.1 Women's Own Health Needs Versus the Health Needs of Others

A part of being a woman in Serbia, as in many other parts of the world, is acting as a nurturer and taking care of others, including maintaining their health. However, it is particularly salient in this culture in which self-sacrifice is a socially accepted mode of behavior for women.

When asked how often they go to see a gynecologist, most of the respondents in my study said that they go very rarely, if ever, depending on their other duties, particularly family obligations. Women's irregular patterns of visiting gynecologists for check-ups seems to be connected with their dedication to taking care of other's health, primarily the health of their children, their parents/parents-in-law, as well as their husband.

When asked why she did not go to see the doctor about her prolonged periods and excessive bleeding, Divna (age 60) provided several reasons, one of which is the following:

Well, I couldn't go to see the doctor because I had all these things I had to do every day: get up in the morning, give breakfast to my children and husband,

feed the chickens and cows²⁷, help my mother-in-law get up and get ready because she was sick, bring morning coffee to my father-in-law, wait for my husband to get back from work so that I can give him his lunch, feed the children, clean the house and sweep the yard, tend to the animals, and so on and on. [...] It never ends, you know, all the things you need to do during the day. That's a women's life. And doctors aren't working at night when you're finally done and you have to go all the way to Belgrade to see a good doctor, you know, the doctor for women, how do you call that?. [...] And it's not so important for me, it's important that the children are good and healthy, God bless them. And I couldn't leave my mother-in-law alone, when she couldn't walk by herself, she couldn't even use the bathroom on her own, so [...]. There was really never enough time for me for go and see the doctor in the city.

Ivanka (age 56) reported that the children were “always sick with this or that, fever, sore throat” and that she couldn't leave them to go and see the doctor for something that “may not be such a big deal after all.” She also stated that she didn't want her in-laws and husband to think that she was “spoilt for running to the doctor every now and then for every little thing.”

Milena (age 47) stated that she did not have the time to visit her gynecologist on a regular basis because she had to go to work, take care of the kids, and also help her husband who had serious problems with his kidneys, so he needed her constant care. In addition to that, Milena shared the following:

And I don't have a daughter to help me with the housework and all that stuff that every woman has to do every day, so I was too busy to go deal with my own health issues. I just thought it will pass; it will just go away the same way it came. You know what they say: “A wound on a dog heals on a dog²⁸.” But it happened that I was wrong about it this time.

²⁷ In this period of her life, preceding her hysterectomy, Divna lived with her family (including her in-laws) in a village in the relative vicinity of Belgrade, so a number of her duties included dealing with farmyard animals. Later on, she moved to Belgrade to stay with her son and his wife.

²⁸ A Serbian saying, meaning that it is a little problem which will pass soon without having any serious consequences.

Additionally, based on the respondents' stories, it seemed that their family members were surprised when they got sick, because they perceived these women as the ones taking care of others and not ones that should be taken care of. Maja (age 55) reported:

I am pretty much never sick, I hardly ever go to see a doctor, and when I do get sick on the odd occasion, my entire family gets shocked because I just never get sick. That's something I don't do. Everybody else can get sick, but not me! [laughs]. My husband is used to me always being around to tend to his needs and to take care of him, and he was so shocked when I actually got sick in the end, that he simply couldn't accept it as reality. He was completely dazed, as a sleepwalker, and kept asking me: "How can this be? How can this be?"

Another study participant, Marina (45), recalled how her family members were astounded when she told them she had to go to the hospital for her hysterectomy:

I told them that I made arrangements with my doctor and that I will have to go to the hospital for a week or so and they were all so surprised, like [...] they were all staring at me like dumbstruck, you know. As if I just told them something completely ridiculous, you know, something insane. [...] And it's not like my husband didn't know anything about my health situation; he did, we talked about it, he was just so shocked that it was really happening, that I would have to go to the hospital, because [...] because I really used to be so healthy all my life. And I always took care of my husband and kids, so what's all this all of a sudden, you know? It was funny, actually, how they reacted. [laughs]. Silly, really.

As evident from my data, most women who participated in my study believe that their personal health comes after the health of their family members and they try not to seem "selfish" or "spoilt" by visiting a gynecologist on a regular basis or appearing to take too much care of their own health. This attitude is certainly caused and promoted by the generally accepted concept of female self-sacrifice, which forces women to neglect their own needs so that they do not seem "selfish" and "spoilt" in the eyes of others. This

further complicates and makes difficult the possibility of early detection of gynecological problems and their timely treatment.

4.3.2 Gynecological Health Screening Practices and Access to Health Education

According to Markovic et al. (2005), “[T]he interplay of social and personal barriers influence[s] [Serbian] women’s poor presentation for [gynecological] screening. Inadequate public health education, lack of patient-friendly health services, socio-cultural health beliefs, gender roles, and personal difficulties [are] the most salient barriers to screening” (p. 2528). My own findings reiterate these problematic women’s health issues.

Most of my participants reported they are very poorly informed about the necessity of regular gynecological screenings. In addition, my respondents’ remarks were similar to those of women who participated in Markovic et al.’s focus groups, namely that “the majority of patients present[s] to any health care professional, including a gynecologist, only for curative rather than preventive health care. [...] This individual health behavior, women argued, was shaped by inadequate patient health education, including from gynecologists” (p. 2531). In that vein, one of my respondents, Branka (age 51), reported:

Nobody ever told me that I should have regular checkups and Pap smears until I had my hysterectomy. I know that some of the women working in big state-run companies and factories used to have obligatory screenings at work but I never worked in a place like that, so I never went. I really had no idea how important it could be. If I did, I would have probably gone to see the doctor more often or sooner than I did.

Another participant, Divna, in her discussion about curative versus preventive purposes for visiting a gynecologist stated:

Why would I go to see that women's doctor if I'm not sick? You travel all the way to Belgrade to do that and then they tell you, 'Why did you come? You're not sick! Go home, there are many other women that are sick here.' So I never went, because other women told me about this and I knew it myself. I went to see the doctor when I started bleeding a lot, because I had to. Why would I go before? I don't have time or money for that kind of thing.

Talking about the same issue Beba (age 40) stated:

I went to this state hospital once to have my check-up and after they took a Pap smear I asked the doctor when I should come again for my next-check up. He was very vague about it, he told me to come when I felt like I needed to come. How the hell do I know when I will need it? I am not a doctor to know that kind of thing! They are supposed to educate women about these things, not be so lax about it! I know they don't get paid enough in these state institutions but if I went to this same doctor's private office, he would have told me: "Oh, come again in six months," because he earns money that way. That's how he feeds his children. But in a state hospital they won't tell you that. And I don't have that kind of money to go and see a private gynecologist every six months.

Ana (52) shared her experience:

I didn't know I was supposed to show up for screening every six months or a year, but I tried to go regularly and show up every two to three years because I realized it could be important for a woman. I talked to my friends and neighbors who knew more about it and they recommended regular check-ups. And it turned out it was important, because if I went later than I did, it might have gotten much, much more serious than it was. [...] But it's hard to go, you know, if you don't have lots of money to go and see a private gynecologist. Doctors can get really edgy sometimes, and rude! When [...] when I went to see this gynecologist in this state clinic, I asked him if he thought the instruments were sterilized, and he got mad with me and told me: "If you're so concerned with sterility of my instruments, why don't you nicely go to see a private gynecologist, pay good money, and ask him that question?" I was shocked! I didn't want to go back there ever again! And yes, it costs more money to go and see a private gynecologist but at least they treat you right, 'cause you're paying them good money for it!

Many of my participants' stories about their experience with gynecological screening highlight not only the issues of poor patient education, but also issues such as doctors "reinforc[ing] patient's beliefs that only the presence of illness justifie[s] access to health care" (Markovic et. al., 2005, p. 2531); patients' inability to discuss and negotiate their

own health care with a physician; and the general poor status of the public health system and economy in Serbia, which forces some medical doctors to treat patients better in their private practice than in state hospitals.

One participant, Vera (age 48), experienced an uncommon instance of medical malpractice which was extremely frustrating for her. Even though I had only one participant in my study reporting such an incident, so it does not constitute a pattern on its own, I thought this story adds to the general idea of the state that public health services in Serbia are in currently, and illustrates how detrimental bad patient-physician communication can be:

I had a total hysterectomy because I had uterine fibroids and they were growing rapidly and [...] my uterus was the size of a child's head, so [...] doctors urged me to have a hysterectomy. I think it was all because of the spiral²⁹—I had it for twelve years and it totally messed me up [um] my periods started getting more and more profuse. I was pressured by the doctors to have a spiral [...] I was kind of forced into that [...] The thing was, I had an operation of thyroid gland and I didn't get my period two weeks after the surgery so I called the nurse and asked if that was normal and she said yes, that's a reaction some patients have, so I should just wait and it will come. But it didn't [...] and I was also nauseated and I was feeling really bad, physically. I was extremely unhappy that I had to have an abortion, I never thought I would have an abortion, I thought I would always give birth when I get pregnant and so [...] I was very unhappy that I had to do it. And before the abortion was performed, there were twenty of us in there or so, and doctors gave us a lecture on birth control and gave us these spirals, they were plastic, and they were probably not good, they were low quality and [...] and I kept telling them that I don't want it now that I will come back and get one, that I'm not ready and [...] I needed to recover from the abortion first, right, but [...] but the doctor said no, when you come back you will already be pregnant again. And so [um] they put this spiral in me and [...] I didn't want it, I was afraid. But I couldn't fight them off, I just couldn't persuade them. They just simply [...] there was no way I could say no, 'cause they pressured me so much. And I was

²⁹ The "spiral" Vera is referring to is an Intrauterine Device (IUD), a small object that is surgically inserted through the cervix and placed in the uterus to prevent pregnancy. The IUD is not noticeable during intercourse.

so scared. But they really insisted on it. Afterwards, I felt like I was raped, literally. And I couldn't stop crying for days.

On the other hand, there were some instances of excellent doctor-patient communication, which helped women considerably in restoring their gender identity following hysterectomy and relieving their fears and anxieties. As Zora³⁰ (53) states:

I am very disciplined when it comes to gynecological examinations, but that's just the way I am. I know very few other women who are like that [...] most of them hardly ever go to see a gynecologist. Maybe it's a lack of education or maybe financial issues, I'm not sure. But I [...] I have examinations every six months, that's what I've been doing ever since I became sexually active. I knew I had a fibroid attached to my left ovary, but at one point it started growing rapidly and I was bleeding a lot, and my doctor urged me to have a hysterectomy. It was really huge [the fibroid], the size of an infant's head. So he removed my uterus and my left ovary. For me, that was a very rational decision and there was no sentimentality because my doctor explained how important it was. I have a wonderful relationship with my doctor, he delivered my younger son, and when I went into the operation room I didn't feel any fear because I knew he would be there, so I was completely ready. We talked about everything before the hysterectomy and also afterwards. He assured me that I needed to have an operation but that I will be completely normal afterwards, that I will be as valuable a person and a woman as I ever was and that my sexual feeling will not be changed, that it even may get better because I won't have to worry about pregnancy any more. And he was right. So I never doubted my own value, as a woman. He always calls me 'Sweetie,' and he is so wonderful and [...] and the other two women who were sharing the room with me in the hospital, who also had hysterectomies, they were very grateful that he came and talked to me at length after the surgery, because that way they got to hear and learn a lot, and many of their questions got answered.

Maja also reported that she had excellent communication with her doctor:

He was ready to answer every little question I had and I felt very safe that he will do the job right. He is an excellent doctor, with a vast experience, and he has a lot of patience, which I think is important. He respects his patients, respects their opinions and is willing to listen to you and hear what you have to say. Which I think is quite normal, having in mind that you are the person being treated in the first place. He really put my mind to rest and calmed my nerves right before the surgery.

³⁰ Zora had a hysterectomy eleven years before the interview, when she was 41 and a half years of age.

4.3.3 Coping with Health-related Uncertainties

According to Hines (2001), “several studies now support the claim that persons will attempt to reduce uncertainty when they expect the outcome will be positive and that they will at times attempt to preserve or increase the level of uncertainty when the outcome is expected to be negative” (p. 502). Furthermore, Hines (2001) expects “the efforts to manage uncertainty related to one issue will be less likely if the person believes that these efforts will create greater uncertainties about even more important issues” (p. 502). For instance, one of my participants, Tamara (age 34), was postponing visiting the doctor about her gynecological problems (excessive bleeding between periods, inexplicable abdominal pain, etc.) due to her fear that, if a serious gynecological issue was discovered she would jeopardize her relationship with her male partner and, “totally spoil his pleasure” and “make him resent [her]”.

Additionally, Divna, who was afraid all her life that she would be diagnosed with cancer, refused to go and see a doctor when she started bleeding profusely and kept postponing the visit until her son physically forced her to go and get examined after she fainted due to the excessive loss of blood. What complicated the situation further was the fact that Divna was afraid that her husband would “leave her if he discovered [she] had the worst thing of all.” According to Hines (2001), “such reasoning suggests that a particular uncertainty management strategy is more likely to be used when the strategy’s use will produce a positive effect on others. Expectations that others will respond negatively to a particular strategy are likely to decrease the chance that strategy will be used” (p. 503).

Moreover, according to Hines (2001), “if a person’s family belongs to a culture that believes talking about illness should be avoided because it can cause the illness to occur, that person may be unable to obtain information about her illness that may facilitate coping” (p. 503). In the case of Divna, she was unable to share her fear and anxiety over her condition with her husband and other family members at first, because she feared their reaction and fear and irritation her communication about it may cause. That is why she chose to wait, postpone her visit to the doctor and avoid uncertainty reduction by refusing to deal with her fears, doubts, and uncertainties.

While discussing my future research with several of my family members, I had to face the same kind of rejection and fear caused by their alarm that talking about ‘these things’ (which they did not even want to name or qualify) may bring the ‘misfortune’ upon those who communicate about them and ‘invoke evil.’ I came across such superstitious beliefs even in very educated people from Serbia who were literally afraid to discuss certain ‘burning’ topics (especially those health and disease related) for the fear of jinx or ‘evil eye.’

In conclusion, it is evident from my respondents’ stories that they, as many Serbian women, pay little attention to their own basic health care, pay more attention to the health of their family members than their own, are very poorly informed about the necessity of regular gynecological screenings, often have poor communication with their health providers, and have difficulties coping with health-related uncertainties. These findings underscore it is necessary to help women change their general negative attitude towards their own health and perceive it as imperative for their survival.

4.4 Spirituality and Religion in Relation to Hysterectomy Experience

Several studies conducted in the U.S. and Canada (Lalinec-Michaud & Engelsmann, 1989; Galavotti & Richter, 2000; Williams & Clark, 2000) briefly indicate that women with a lived experience of hysterectomy placed importance on spirituality and prayer and expressed “heavy reliance on their spiritual faith to get them through the hysterectomy experience” (Williams & Clark, 2000, p. S-24). However, none of these studies addressed this factor in-depth and most concluded that these issues needed to be addressed in future research. Although the issue of spirituality and religion in relation to hysterectomy experience was not addressed in my research questions, it emerged during the interviews. Thus, I have included this theme in my analysis and believe that it plays an important role in Serbian culture as a whole, and therefore should not be neglected in this discussion. That said, only four of my participants directly addressed issues related to spirituality and religion in their narratives, which limits the degree to which I can emphasize its influence with my respondents.

4.4.1 Religion and Spirituality in Serbia

The predominant religion in Serbia is Orthodox Christianity. There are also other religious communities in Serbia, such as Islamic, Roman Catholic, Protestant, Jewish and others; however most Serbs identify themselves as Orthodox Christians and their religious beliefs represent an essential part of their national identity. According to the 1991 census, 87% of citizens of Belgrade declared themselves as Orthodox Christian, 2% belong to the Islamic or Catholic religion, 0.2% are Protestants, 0.03% are Jews, 6% belong to unspecified religions, while 3% have stated that they are non-believers. In

addition, religion plays an important role in beliefs related to health and healing among Serbian people. Religious people in Serbia place a great amount of faith in holy men (mostly monks believed to possess healing powers and clairvoyance), male and female³¹ saints, holy springs, holy relics of saints, holy icons, etc., which are believed to bring much desired relief from all sorts of physical and mental ailments. Moreover, according to Christian teachings, woman, represented by Eve, is seen as a sinner, and her very nature is considered to be wicked and errant, so for many Serbian Orthodox Christian women, inherent female sin represents not only a traditional belief but also a reality, which urges them to blame themselves for numerous actual and imaginary transgressions.

4.4.2 Stories of Health beyond Medicine

One of the types of stories that facilitate the essential role of narrative as a sense-making device is *health beyond medicine*, which incorporates alternative forms or methods of healing (Sharf & Vanderford, 2003), including spiritual healing. Even though it cannot be identified as a predominant attitude among the participants in my study, several women expressed the importance of their religious feelings in their adjustment to the idea of hysterectomy as well as the recuperation process following the procedure.

³¹ Mostly Virgin Mary and Saint Petka (Paraskeva), the protector of women (especially pregnant women) and children. St. Petka's holy relics were placed in the Church of St. Petka built in Belgrade in 1417 and are believed to have performed numerous miracles, as well as is the adjacent holy spring dedicated to St. Petka.

Throughout Maja's (age 55) narrative, she referred to God as her main solace on whom she was greatly dependant throughout her experience of hysterectomy, and the only reason she managed to successfully cope with it.

In the first part of her story about health beyond medicine, Maja talked about her faith in Virgin Mary and her firm belief that the Virgin was the one who helped her and that it was no coincidence at all that her surgery was scheduled the day before the Feast of the Dormition³² of Mother Mary:

I think it was my faith in God that made this experience so much easier. I had my surgery on August 27, right before the Feast of the Dormition of the Mother of God³³, which is also the day when I was baptized, and I was somehow completely certain that Mother of God would help me and save me. I always pray to Virgin Mary in difficult moments in life...(pause) so that the very date when my surgery was scheduled gave me some self-confidence.

Furthermore, she viewed prayer as a vehicle that helped her directly communicate with God in the chaotic circumstances in which she found herself and determined that she could not handle alone because the complexity of the situation required someone greater than mere mortals to intervene:

I went to see a doctor and my Pap smear was positive, group 3, so the doctor wanted me to have a colposcopy as a follow-up for the abnormal Pap smear and colposcopy showed that there were some pathological changes, and then I had a biopsy which showed I definitely had cancer but they also told me that it was in the very initial phase. That was at the same time defeating and comforting for me to hear; on one hand I didn't expect it to be cancer and on the other hand I was glad to hear that they discovered it on time. [...] My husband was with me when I learned my diagnosis and we went home and he immediately called my gynecologist and told him about my results, and my husband was really panicky

³² The Dormition of the Theotokos is the Eastern Orthodox commemoration of the "falling asleep" or death of Virgin Mary, the mother of Jesus. It is celebrated on August 15 (August 28 according to the Old Style or Julian Calendar) as the Feast of the Dormition of the Mother of God. It is preceded by a two-week fast from meat, dairy and oil.

all along and I was calm because that's my reaction to other's people's panic—I gather up all my strength to calm that other person down, so maybe his panic somehow helped me get myself together. I kept telling him that everything will be OK, that God is watching over us and that there is no reason to be worried, and then I suggested him that we should go to church and ask the priest to say a prayer for my health. I kept telling him that I was deeply convinced that God would help me—as I was. And we went to see the priest, maybe two hours after I found out about my diagnosis. We went to the church and we found our priest and I told him: “Father, I want to ask you to say a prayer for my health” and he asked: “A prayer for you personally?” and I said, “Yes, I am sick, I'm not sure to what degree, I will know soon, and I need God's help” and then he asked me: “Do you believe that prayer can help you?” and I said, “I believe” and he replied: “Then it will help you.” And I really felt, after that prayer, I felt extremely safe, I got additional strength that I would manage to win that battle and that it wouldn't be fatal, that everything would be all right. And it was.

Each of the two excerpts mentioned above indicates a reliance on God's help.

For example, Maja views prayer as a means of direct communication with God, as well as a means of dealing with own fear and her husband's panic, that could have paralyzed her and prevented her from dealing with the reality of her health situation. Maja perceived this alternative to medicine—prayer—as a genuine, plausible, and engaging way to deal with her psychological tension and pursue health and healing.

Similar to Maja, Nina (age 35) also reported great reliance on God's will and help:

When I was told that I was sick and that hysterectomy cannot be further postponed, I prayed to God for help and serenity. I am a medical doctor myself and I was fully aware of the fact that I will not be able to have children after the surgical procedure, as well as all the other health-related implications. But that didn't help me cope with it, not all the knowledge I got from medical books. [...] [aaah] What helped me was my faith in God, my constant prayers, and my belief, no, my [...] my knowledge that there is a whole other life for me, after this suffering is over. And the more I suffer here, the more I repent, the better and more glorious it would be there. At first I couldn't let go because I was so afraid that I will lose my life in the world, I [...] I just couldn't let go of it [...] the knowledge that I will never get to be a mother devastated me, because that is something I always wanted. I really love children, you know, and they come to

my office on [a] daily basis, and that kept reminding me of something I will never have [...] but then I made my peace with it and said to myself: “This is how God wants it, and God has his reasons. And if you really believe in Him, you must accept His will.” I struggled with that at first, with fully accepting that [...] but then I finally realized that He is the only reality and the only Truth.

For Nina, choosing God over her own “selfish” desires was a way to find meaning and serenity in her otherwise devastated life devoid of motherhood, which represents a successful survival technique and a way to heal herself and reconstruct her own identity around her newly-found center—religion.

Another respondent, Divna (age 60), had a great fear of cancer throughout her adult life, due to a family history of breast cancer. It was a paralyzing fear, which distracted her in her attempts to lead a normal, anxiety-free life. When she was forced to visit the doctor due to constant, heavy bleeding, she was convinced she had cancer, and was completely immobilized with horror. Instead of discussing her fears with a medical doctor or a family member she went to the church and prayed to Saint Petka. This is a fragment of her account of that episode:

I was so scared that I couldn't walk properly, I kept dragging my feet, and this nice woman had to help me down the stairs to the church. I was walking and walking and [...] it was like I was getting nowhere. And I stumbled a lot. [Aaah] And then I got to the church, I drank water from the spring and I was praying to Petka to help me, to save me from the worst thing of all. [Oooh] It was hard on me, all that. So I prayed and prayed and kissed the icon of St. Petka and the icon of Virgin Mary and left as much money at the church as I could. I would have given more, but I had these medications I had to take, and they cost money you know [...] so [...] so I prayed and I cried, and St. Petka helped me, she helped me [aaah] Yes. I confessed my sins to the priest in the Church of St. Petka and she helped me [...] In the end, it turned out I didn't have cancer after all.

4.4.3 Narrative as Assigning Responsibility and Blame

According to Sharf and Vanderford (2003), “narrative sense-making frequently involves assigning responsibility and sometimes blame” (p. 19). In the case of all four participants in my study who engaged in the responsibility-and blame-assigning process, it was strongly connected to their religious feelings and beliefs, namely the concept of “sin” as defined by Christianity.

Divna thought she was being punished for not going to church on a regular basis and for failing to confess some of her “sins,” such as a number of abortions she had, so she consciously placed blame for her health problems onto herself. She asserted:

I know it wasn't good what I was doing, that I shouldn't have done it. I shouldn't have killed my children. So God punished me and wouldn't let me have more children 'cause I was killing them before. But I thought that my husband was protecting me from getting a child. I am not an educated woman, and what do I know? I listened to my husband and he said: “Divna, don't you worry I am protecting you, I am paying attention to it.” What do I know how he does it? He is the man, he should know. But it's my fault, 'cause I should have known better than to go get cleaned. But we already had two children and [...] [Aaah] We are not rich people, you know? But it's all my fault, 'cause I should have known better than that. And I never went to church to confess my sins, so God was punishing me. But He didn't punish me all the way, 'cause I confessed my sins in the end and I repented. I could have had more children, I was only 43, but God didn't want me to. But he saved me from cancer. And I am very grateful for that. [...] I am very grateful He forgave me in the end. That's because Saint Petka said a prayer for me, she put in a good word for me [laughs]. That's how it was.

Even though Divna made an attempt in her narrative to put blame on her husband as well, she ended up blaming herself in accordance with Serbian tradition of women being the main culprits for all kinds of actions perceived as sins and transgressions.

Nina, on the other hand, blamed herself for not being able to “let go of her life in the world,” i.e. for her inability to detach herself from her own desires and the secular world, and bring herself closer to God and the spiritual sphere:

I think this was all a sign from God, like some sort of awakening, that was necessary in my life so that I could see the reality hidden behind the material world. I thought I would find happiness with my fiancé and that we would have a family and I was so lulled into that prospect of happiness that I forgot about the essence, I thought only of what was there, on the surface, visible. That was my major sin. So that’s why I told my fiancé to go and find happiness elsewhere because [...] because I [...] I knew my path was supposed to be different. I resented that for a long time but now I accept it completely. And I have no regrets. I remember this TV documentary about a famous monastery in Serbia and [...] and they interviewed a nun, and she said something along the lines of [...] I’m sorry, I can’t remember her exact words, but what she said was [...] it was something like: “You may feel sorry for us living outside ‘the world,’ and for giving up ‘the world,’ but we actually feel sorry for you all for not being able to see the *real* world we experience through our way of life in Christ.” And I remember, when I saw that, I remember I thought: “That’s exactly how it is.” So now I know God wanted me to ‘sober up’ and to see this truth. And I needed this pain so that I could see it. I brought it all onto myself because I was blind. [...] Right now I am considering joining a sisterhood in an Orthodox monastery. But I am also a doctor and can do a lot there as well [...] help people, help children. So I will see what will happen, but now I know that God [aaah] God is leading me in the right direction [smiles].

Through the process of assigning blame, Nina found closure and meaning behind her lived chaos. She found the reasons for why things were not the way she thought they were supposed to be and found a way to accept herself and establish her new identity as a person no longer living “in the world,” but living “in Christ.”

In her quest for meaning and in an attempt to make sense of her lived experience of hysterectomy, Ana (age 52) indirectly, and probably unconsciously, tried to place blame for her hysterectomy onto herself. She believed that, in a way, she brought it all onto herself due to her “mortal sin” of abortion in her younger years. In the following

fragment of her story, Ana explained how she became pregnant a couple years after giving birth to her only son. She had had an exceptionally difficult delivery, which filled her with tremendous fear of going through the same experience again, so she decided to have an abortion. Now she blames herself for it and deeply regrets her decision:

Unfortunately, when I became pregnant again, I regrettably [...] it is a sin against God, I know but [...] I had an abortion. My husband wanted that child, but I, for some reason [...] I wanted my first child so much, but this one, I don't know, I just couldn't stand it [...] I just wanted it out. When I think about it now, I guess I had to be punished in life too, like others are. Had to be a sinner. That's a terrible sin. Now when I think about it, it's a mortal sin. But it probably had to be like that.

In her narrative, Maja blamed herself for getting sick and connected her illness with her despair over her mother's death. She also believed that her sorrow made her forget her faith, and even though she does not believe that God punished her for it in any way, she thinks that she punished herself and believes herself to be the cause of her illness:

After the prayer and talking to the priest I was completely convinced that everything would end well. I simply thought, "OK, God sent me a temptation, but with God's help I will prevail." I don't think I am a great Christian—I am just an ordinary believer and an ordinary Christian so God sent me this little temptation, although I think illness is a great temptation for any person, but also some Christians actually ask for illness in order to purify themselves through it. I was aware that illness is some sort of spiritual purification and I was completely aware that my despair and chaos I was in due to my mother's death weren't a good thing at all and that it all even shook my faith a little bit because if I'm a true believer I should know that my mother is better off where she is right now and that she continues to live there. So in a way, because of my great sorrow, I made it more difficult for her as well. That's what Dostoyevsky is talking about in "Brothers Karamazov." I later understood it all—I don't think that God punished me through this—God doesn't punish anyone, but you punish yourself, I punished myself with my despair.

Evidently, Maja believed that she needed to be punished for her own despair, and since “God doesn’t punish anyone,” she placed blame onto herself and, in a way, penalized herself for losing faith and despairing over the loss of her mother instead of accepting that she had gone to a “better place.” In that sense, Maja considered herself responsible for her own illness. In her mind, her body took on the role of a scapegoat, which took onto itself a part of her negative energy. In that sense, her physical illness became her defense from her unhealthy psychological situation and simultaneously represented a challenge and a warning, reminding her that the final moment has come for her to reexamine her unsolved inner conflicts and discover a different solution for her predicament. She made a conscious effort to concentrate on the joys of her present life with the remaining members of her family and put her sadness behind without forgetting about it. As Frank (1995) puts it, “Losses continue to be mourned, but the emphasis is on gains” (p. 128).

The fact that Maja chose to place blame for her illness onto herself and her despair and direct responsibility inward instead of blaming God or other people in her life, represents a conscious effort to make sense of her illness and put the traumatic experience of her mother’s death behind her so that she could continue with her life in spite of her grief.

In conclusion, Maja’s contemplating her mother’s death instead of her own ailment; Nina’s complete surrender to God’s will; Ana’s need to blame herself for her abortion, which she perceived as a mortal sin; and Divna’s unconditional belief in St. Petka’s healing powers helped them shift the focus from their hysterectomies to what are

for them more fundamental, spiritual issues, which in turn, albeit unconsciously, helped them cope with the more obvious, surface issues of gender identity, intimate partner support, and potentially impaired sexuality.

4.5 The Role of Social Networking in the Lives of Serbian Women

As Denich (1970) and Markovic et al. (2005) assert, “[I]n the absence of effective public services, the population in Serbia has had a long history of people disseminating information and advice through informal conversations” (Markovic et al., 2005. p. 2534). This is certainly true for information related to health issues, especially those related to women and women’s health.

The tradition of coming to one’s friend’s or a neighbor’s house for a cup of coffee and several hours of relaxed conversation is deeply entrenched in Serbian culture, particularly among women. This activity even has a name of its own—“kafenisanje,” which denotes a daily, usually morning or afternoon, activity in which two or often more women discuss important issues in their lives over coffee. Although similar activities exist in other parts of the world as well, in the patriarchal culture of Serbs this used to be, and still is, one of the rare venues in which women get to say what they think and exchange opinions and important knowledge with their peers. While men often consider this activity as “inferior” and regard it with contempt, for many women it is a source of empowerment and a rare opportunity for their voices to be heard.

Even though it was not a predominant theme in the in-depth interviews I conducted with my participants, three participants discussed the great importance of peer support in their experience of hysterectomy, and how understanding, advice, and support

from their peers helped them reframe their identities following hysterectomy procedure. Additionally, many participants made brief references in their narratives to the fact that women usually tend to understand other women better than men do, and stated that they would prefer to discuss certain hysterectomy-related issues with other women who have had a similar experience to discussing them with their family members. For that reason I think it important to include in this report the stories of Serbian women's practice of networking.

As Zora (age 53) reported, she considered it pivotal to share her experience with hysterectomy and techniques that helped her restore her identity with her friends who went through a similar experience:

What I think is important is honesty, openness, and communication, and the willingness to help other women if you can. You need to tell the others of your experience so that they don't get to be burdened by all these negative thoughts, thinking, "I'm not valuable any more," or something silly like that. So I shared everything with my friends and neighbors, and I think it helped them a lot.

Zora, who had her hysterectomy at a relatively early age (41), discussed her experience first with her close friend and neighbor Marina (age 45), and then with her neighbor Ana (age 52), who both had hysterectomies in the same year. She formed a little informal "support group," even though none of the women involved ever heard that term before, but they all felt the need to engage in regular conversations related to hysterectomy in order to share their doubts, fear, and anxieties in the relaxed and non-threatening atmosphere of their respective homes. Another woman, Lela (age 50), joined them after several months, but she was unfortunately unable to participate in my study due to being hospitalized for certain health complications.

Marina reported great satisfaction with their “group sessions” and suggested she would recommend such a thing to other women as well:

Zora was great, she was able to answer questions that I was ashamed to ask my doctor [laughs]. I could talk to her about sex as well, especially because she has known my husband and me for years, so we are practically family. I didn't know what I would have done without her. I am a shy person myself, unlike her, so I couldn't really talk about these issues with my husband even. But she made me feel good about myself and she explained that I am not less of a woman now that my uterus has been removed, that I am equally valuable as I was before the surgery. We were able to talk about private issues, such as vaginal lubrication and stuff like that, things that you wouldn't normally feel comfortable talking about with just anyone. But [...] but she made me feel comfortable talking about all that because I knew she went through the same thing and it really helped me a lot. Every woman should try this! [laughs].

Ana stated that talking to Zora and Marina helped her overcome her depression:

I said this before, I was very depressed over the loss of my uterus. My husband was very supportive, but [...] I didn't always feel comfortable talking to him about certain things. Some things are shared more easily with another woman, you know. I've been neighbors with Zora and Marina for ages but we were never very close until Marina and I had our hysterectomies. We had them at the same hospital, so that's how I knew about it. [...] Later, when I was fighting my depression, I ran into Marina at the grocery store and we started talking and [...] and she suggested I should come and have coffee with Zora and her sometime, so I did, and we started talking about my hysterectomy and their experiences and [...] it meant a great deal to me, really. We talked about everything and I even told them how I felt about my abortions [...] it was like seeing a psychiatrist, in a way, only better! [laughs]. Because [...] psychiatrist can help you but he can never know how you feel exactly and they did know [...] they knew exactly how I felt and what I was afraid of. And Zora has this great doctor who operated on her, so she told us what he told her and it really helped. It was like being reborn!

At the end of our interview, Zora told me:

I told my friends, especially Lela, before she had her surgery, I told her: when you go to see your doctor, tell him everything openly, tell him about all your problems, ask all the questions you need to ask, and it will help your doctor know what you are going through. Don't be ashamed, or scared, it's all normal, it's all human. And don't feel like you are anything less than you used to be before your surgery, because you're not. You are wonderful human beings, wonderful women, and nothing's changed about that. Nothing whatsoever. So they knew

my door was always open to them and that here they could talk about all those things that were troubling them. It made me feel wonderful that I was able to share my positive experience with my friends and help them as well.

As Sharf and Vanderford (2003) assert, stories may serve as a tools for building community. Sharf and Vanderford (2003) further discuss how, through the process of *symbolic convergence* conceptualized by Ernest Bormann (1985), “multiple individuals or organized groups are attracted to and build upon stories [*fantasy themes*], leading to the development of rhetorical visions that provide common histories, coherent depictions of current reality, and desire for the way the world should be” (pp. 26-27).

Through the process of symbolic convergence, my participants Zora, Ana, and Marina, as well as their friend and neighbor Lela, managed to provide support to each other, simultaneously satisfying their emotional needs in ways their family members and health care providers were unable to. Furthermore, by recognizing enough similarities among themselves, developing a comfortable group atmosphere, and engaging in a process of self-disclosure, these four women successfully managed to “build a sense of community or a group consciousness” through symbolic convergence (Griffin, 1991, p. 34).

As Markovic et al. (2005) affirm, “Enhancing women’s health education through peers may be used in addition to the information in the media” (p. 2534), which would be particularly salient in the case of gynecological problems, which women sometimes feel too ashamed to discuss with family members or physicians but would not feel as threatened when discussing them with another women who had a similar experience. Therefore, the importance of peer communication and individuals disseminating

information and advice through informal conversations with non-threatening persons from the same community in Serbia is great and would fit the traditional concept of women's practice of networking which most women in Serbia find highly acceptable.

4.6 Conclusion

Stigma can be defined as a visible or invisible trait that departs from “the ordinary and usual” and whose carrier is discredited by his or her social milieu and redefined from a “whole and usual person to a tainted, discounted one”(Goffman, 1963, p. 3). Furthermore, as Goffman (1963) argues, society tends to stigmatize certain illnesses and health conditions, influencing an individual's preferred identity, i.e. labeling a person as someone *not normal* or *not complete*. As shown in this chapter, there are several ways in which having a hysterectomy stigmatized women who participated in my study, made them feel inadequate, incomplete, or faulty; or affected their feelings of gender identity, and decreased their feelings of social acceptability or normality; however, many participants were able to overcome the stigma and successfully restore their identity in spite of many obstacles.

As Remennick (2000) states, “An essential mental source for resisting stigma is the ability to disconnect from the dominant discourse, to assume a critical stance, which usually comes with education” (p. 837). Some of the women in my study, such as Vera, Ana, and Jelena, regardless of their educational level, managed to do so through their open communication with their relational partners and aided by their partner's love, support, patience, and understanding. Other participants, such as Zora, Ana, and Marina, managed to restore their “spoiled identity” (Goffman, 1963), by successful

communication with their peers and sharing their common histories, developing a comfortable group atmosphere, and engaging in a process of self-disclosure. Others, such as Maja, Nina, and Divna managed to find solace and reframe their identity by relying on God's help. Yet others, namely Tamara and Rada, found a way to reconstruct their identities outside the traditional motherhood scheme through contemplating adoption and other alternative ways of performing non-biological motherhood. For Tamara, it was imperative to “disconnect herself from the dominant discourse” (Remennick, 2000) by dislocating herself to the U.S., where she found it easier to leave Serbian cultural limitations behind her.

Carbaugh (1996) states that individual and collective identities are narratively constructed and damaged. On the other hand, Lindemann-Nelson (2001) and White & Epston (1990) assert, identities can also be narratively repaired. Carabas and Harter (2005) affirm, “The voicing of personal and collective counter-narratives can liberate and heal just as dominant stories often marginalize [...] Thus, counter-narratives become a way for people to heal their personal and collective past and embark on a new beginning” (pp. 164-5). Many participants in my study managed to do just that—by deconstructing master narratives, such as that of imperative self-sacrificing biological motherhood, for instance, and replacing them with alternative counter-stories, which serve to reinvent and reframe their identities and their lives. I can only hope their stories will help others to achieve the same.

CHAPTER V

SUMMARY AND CONCLUSIONS

5.1 Discussion

In the study of hysterectomies and gender identity among Serbian women several major themes identified, discussed, and analyzed throughout this report, particularly in the previous chapter, play a fundamental role determining the type of a woman's emotional reaction to hysterectomy.

The following three themes: *Serbian culture of imperative motherhood, the role of relational partners, and stigmatization and stigma potential* were foreseen in my research questions, as stated in the Chapter I of this report. However the next three themes: *women's health beliefs and practices, spirituality and religion in relation to hysterectomy experience, and the role of social networking in the lives of Serbian women*, even though not originally envisioned by my research questions, needed to be addressed as well, since they emerged from the data gathered through in-depth interviews. The following is the list of all emerging themes addressed in this report and the issues they encompass:

1. *Serbian culture of imperative motherhood* (including the culturally important components of womanhood, with primary emphasis on motherhood); issues of sterility and childlessness; inability to bear more children; and adoption and other alternative ways of performing non-biological motherhood)

2. *The role of relational partners* (including the relationship among sexuality, body image, and gender identity; the quality of partner communication; and the importance of partner's support and acceptance)
3. *Women's health beliefs and practices* (women's own health needs versus the health needs of others; gynecological health screening practices and access to health education in Serbia; instances of medical malpractice and instances of excellent doctor-patient communication; and coping with health-related uncertainties)
4. *Spirituality and religion in relation to hysterectomy experience* (religion and spirituality in Serbia; stories of health beyond medicine; and narrative as assigning responsibility and blame)
5. *The role of social networking in the lives of Serbian women* (the importance of peer communication and individuals disseminating information and advice through informal conversations with non-threatening persons from the same community—"women's practice of networking")
6. *Stigmatization and stigma potential* (ways in which hysterectomy may stigmatize women and affect their feelings of gender identity and social acceptability (normality) and resisting stigma (restoring identity and performing femininity))

As evident in Chapter IV of this report, these six prominent themes which emerged from the in-depth interviews I conducted with my participants are all embedded in the fabric of Serbian culture and represent the summary of most common reactions,

fears, anxieties, problems, attitudes, and beliefs Serbian women with hysterectomies may have or experience before or following the hysterectomy procedure.

Even though most of the above listed themes are closely connected to the particular nature of the unique Serbian experience of being a woman with a hysterectomy, the findings of this research are not dissimilar to the number of other studies conducted in other cultures on the effect of hysterectomy on male-female relationships and the importance of support provided by husbands or sexual partners on reducing women's fears and anxieties related to hysterectomy (e.g. Bernhard, 1992; Richter et al., 2000).

Since the current study results are based on qualitative methodology using a nonrandom sample of women residing in the capital of a single European country, the results cannot be generalized to all women. However, this is the first study that identifies ethnicity and nationality related issues influencing women's hysterectomy experience and the experience of their partners, i.e., takes important cultural factors into account, analyzes them, and attempts to identify social, historical, and cultural reasons for their existence. Furthermore, unlike the previous studies dealing with the hysterectomy experience, the current study identifies and provides explanation about the role of the social community, especially the roles other females play in influencing the attitudes of women with the lived experience of hysterectomy and the impact other women's attitudes may have on their gender identity. Finally, the current study recognized the necessity for improvement of health services offered to Serbian women with hysterectomy experience and especially the importance of establishing support and self-

help groups to help women deal with hysterectomy related issues, such as fears, anxieties, insecurities, communication problems, and impaired gender identity and gender identity shifts.

5.2 Implications

Findings from this study have implications for members of Serbian culture, especially women with lived hysterectomy experience or those contemplating hysterectomy; their relational partners, family and friends; other researchers; as well as health providers and policy makers in Serbia and other countries with similar political, social, historical, or cultural background.

5.2.1 Implications for Health Care Providers

When a woman is contemplating a hysterectomy, it is pivotal for healthcare providers to supply enough information about the hysterectomy procedure; to facilitate the decision-making process and discuss the alternatives; to include significant others in the process whenever appropriate; and to provide adequate psychological support for women with hysterectomies when needed. In addition to this, if financial resources allow, at least some of the health institutions in Serbia should consider the possibility of offering the following services to women with hysterectomies: offering care plans which include sensitivity to cultural and spiritual/religious issues, especially those related to the Serbian practice of self-sacrificial motherhood and to Orthodox Christianity, as the most widely accepted religious belief in Serbia; organizing and/or referring to meetings with trained experts and other women who have been through similar experiences, in order to help women realize that they are not alone; and incorporating several follow-ups

(including long-term ones) following the surgery to facilitate women's coping with hysterectomy. Moreover, it is crucial to provide better patient education in Serbia on the importance of regular check-ups and gynecological screenings, as well as to reduce fears and anxieties of women facing hysterectomy by assuring better patient-physician communication through continuous professional development (e.g. lectures or seminars for medical doctors).

5.2.2 Importance of Self-help Groups

The findings of this study reiterate the need for popularization and formation of self-help groups for women who have undergone hysterectomy as well as for women with other types of gynecological conditions in Serbia, as previously stated in this report. As Sharf (1997) asserts, "disease-focused groups provide unusual opportunities for information exchange and mutual support among people who face special health interests and vulnerabilities" (p. 66). Such social groups would, in correlation with the discussion of the current absence of effective public services within the health sector in Serbia, represent a relatively inexpensive way to provide women with the much needed support and understanding of other women who have experienced the same or similar doubts, fears, and identity shifts. In that sense, support and self-help groups would serve as an adequate solution until and after the public health services in Serbia have been sufficiently developed. Furthermore, in the case of Serbia, such an approach would be particularly appropriate and salient, not only because there are very few, if any, effective alternatives offered by the official health institutions, but also because:

- Participation in support/self-help groups is free of charge, which is particularly important in the present unfavorable economic situation, especially since there are virtually no Internet-based support groups for women with hysterectomy experience in Serbia and
- The population in Serbia, especially female inhabitants, has a long history of distributing information and advice through informal face-to-face conversations with their peers (Denich, 1970; Markovic et al., 2005). This cultural pattern would make support/self-help groups a natural choice for many women who are used to seeking support from their peers (e.g. relatives, neighbors, etc.) in their immediate surroundings on an everyday basis, but who would feel uncomfortable discussing intimate issues associated with hysterectomy with these neighbors and relatives, especially those who lack personal experience.

As previously mentioned in Chapter I of this report, similar support/self-help groups have already been established in Serbia by the Autonomous Women's Center in Belgrade and other female organizations in Serbia. The support/self-help groups currently offered by the Autonomous Women's Center are intended for women who have had a mastectomy and women victims of family violence. The groups are intended for women's empowerment and are designed to help them: find their inner sources of strength, develop healthy survival mechanisms, and cope with social stigmatization. The number of participants is usually between six and ten, as well as two group leaders/facilitators. One of them is an 'expert by experience,' i.e., a woman who used to be a group member herself and has her own personal experience in the matter but does

not enforce it onto others. The other one is referred to as the ‘ally,’ who knows how to listen actively, can deal with other women’s emotions, is supportive of others, can distance herself from her own problems, and trusts her own intuition (Autonomni zenski centar, 2007). All the support/self-help group meetings are held in the pleasant, safe environment of the Autonomous Women’s Center in Belgrade.

There is an initiative for forming a group for women with gynecological problems and sterility issues, including hysterectomy, but due to the lack of financial support and donations, such a group has not been formed yet. However, I hope that raising awareness of these issues will help provide the necessary funding for such projects crucial for further development of Serbian society and giving adequate support to Serbian females, not only in Belgrade, but also in other Serbian cities and towns.

5.3 Reducing Public Stigma and Providing More Information

There is a clear necessity for reduction of the public stigma assigned to women with hysterectomies and women experiencing sterility problems in general by developing and distributing informational and educational materials which would enlighten the general population and offer them concrete, unbiased information, instead of uneducated beliefs and taboos. Given adequate funding, possible projects would entail: development of brochures, TV and radio shows, series of newspaper articles, collecting official data on the number and nature of hysterectomies on the level of Serbia, and raising awareness of the problematic issues identified and discussed in this report.

Moreover, raising awareness of medical workers towards these women's anxieties, fears and expectations (including those closely related to beliefs and perceptions of Serbian culture) through professional training or a series of lectures would be a helpful strategy in alleviating some of the problems identified in this report.

With regard to relational partners who do not care to understand or are not supportive of problems that women with hysterectomies face, establishing a counseling service, which would also serve an educational purpose, would probably represent a good solution.

As for women with extreme personal reactions and their families coping with different crises related to hysterectomy issues, peer consultants or advocates able to adequately assist the women facing the procedure or following it should be recruited and trained, and their services offered within individual health institutions in which the hysterectomy is performed.

5.3.1 Limitations of the Study and Recommendations for Future Research in Serbia

In this subsection I would like to address the weaknesses and limitations of my study and identify recommendations for future research.

First, the number of female participants (16) I interviewed was large enough to recognize and identify patterns in their narratives, and to record some important, interesting individual stories, but not large enough to provide grounds for generalization of gathered data. This said, what needs to be done in future studies dealing with hysterectomy to be conducted in Serbia is to make the theory identified in this report (or

any other theory that would emerge from future data) more generalizable and applicable to Serbian women in general. Second, participants in my sample were only women from Belgrade, with the exception of one participant who previously lived in a village in the vicinity of Belgrade and later moved to the capital. In order to provide more generalizable conclusions on the issue of hysterectomies among Serbian women, it would be necessary to conduct interviews with women from other cities, towns, and villages in addition to those from Belgrade and include their stories in any future report on this matter. Third, only self-identified heterosexual women were included in my sample due to the social stigma and social disapproval of homosexuals, bisexuals, and lesbians still present in Serbia today. Future research should include experiences of lesbians and bisexual women who have undergone hysterectomies and compare the quality of their partner communication with that of heterosexual women in order to determine whether women partners tend to be more or less supportive than male partners in this matter. Recruitment of self-identified lesbians and bisexual could be potentially achieved with the help of women's organizations such as Autonomous Women's Center in Belgrade, Women's Center from Uzice, and similar female organizations in Serbia. Fourth, this report did not include accounts of male partners due to their reluctance to participate in the study and women's reluctance to include them in the interview process; however, I believe that future research should include male partners as well. One way to make male partners of women with lived experience of hysterectomy more comfortable with the interview process would be to engage a male counterpart to conduct the interviews with men. Furthermore, after identifying male partners willing to participate

in the study, the snowball technique could be employed to recruit more male participants through their personal contacts. Fifth, another source of valuable information could be health-care practitioners from various Serbian cities and towns, who would be willing to share their professional experiences with hysterectomy and even recruit some of their patients to participate in the future studies.

5.4 Conclusion and Suggestions for Future Research Outside Serbia

Based on the findings of this study acquired through the analysis of women's narratives and the additional data gathered through extensive literature and field research presented in this report, it can be concluded that the situation of Serbian women who have had hysterectomies is further complicated by their cultural beliefs and practices, especially the culture of imperative, self-sacrificing motherhood and the dominant social discourse of compulsory motherhood. Other crucial factors in determining the nature and type of Serbian women's reactions following hysterectomy are the type and quality of their communication with their relational partners and others, especially other females in their social networks; and the level of support these individuals are providing; as well as the lack of adequate and affordable health care and psychological services or support/self-help groups specialized for helping women with the lived experience of hysterectomy.

The findings of this study indicate the need for further research to identify cultural beliefs and perceptions of different ethnic groups, in addition to Serbian, that may be linked to hysterectomy experience, especially those from other post-communist societies. Furthermore, there is a clear need for determining the extent to which these

cultural beliefs and practices influence women's sense of self and gender identity following hysterectomy. Future research in this sense should be more specific about women's experiences in the context of post-communist societies and take into consideration the struggle for national identities and the implications it has had on women's personal identities and the notion of motherhood in these respective societies. Moreover, more research is needed related to the role of female peer networks in different cultural circumstances and their impact on women's experience surrounding hysterectomy in order to achieve positive psychological and health outcomes for both women in question, their relational partners, and their respective communities.

Finally, I wish to draw the attention of the scientific community to the fact that in many areas of the world, including Serbia, emotional dilemmas and possible identity crises in relation to cultural patterns and partner communication in women following a hysterectomy have been underrecognized and underresearched and that these issues need to be addressed and possible remedies identified.

5.5 Final Reflections: A More Personal Conclusion

When I reflect on this work, it seems to me that there are two ways for me to look at it: as a communication scholar and as a Serbian woman, with family history of hysterectomy.

As a scholar, I already listed and discussed my findings and presented my conclusions and recommendations for future research. Now I wish to reflect on this study as a person coming from the culture I analyzed in this report and someone going through a certain kind of identity shift herself.

Regardless of any evident experience of Serbian culture, which I share with my participants, as well as my family history of hysterectomy, I have very few things in common with women who agreed to participate in my study. Throughout my work on this thesis, I often considered myself unable to fully understand what they were going through not only because they had a lived experience of hysterectomy, which I did not have, but also because they still live in Serbia, while I reside in the U.S.; and because they are either mothers themselves or consider motherhood as an important component of their identity, while I am not a mother myself and fail to find a palpable connection between my personal identity and the notion of biological motherhood. I find this observation problematic as I continuously, throughout the interview process, felt the need to maintain a close connection with my participants and understand their experience deeply, not as a smug, superior observer who nods her head in bogus understanding, but as another Serbian woman who can truly understand their pains and joys. Over the course of my research and thesis writing, I constantly kept wondering why I failed to experience this feeling of complete belonging. When I reflect upon it now, it seems to me that, even though I was brought up in Serbian culture and many of the personal ties to the culture of my birth remain unsevered, I lost a great deal of my sense of belonging to Serbian culture with my move to the U.S.; in other words, I feel that a separation from the very fabric of Serbian culture occurred at one point in my life. I do not attempt to provide an in-depth analysis of the reasons why this happened here, and I cannot characterize it as either good or bad, but my research and study of Serbian culture made me realize how many of our 'natural' feelings or beliefs are in fact

socialized and socially constructed. I was not aware of this while I was fully immersed in Serbian culture and soaking up its pungent juices. I did not embrace another culture in its place either; on the contrary, at this point in my life I feel like a stateless person or rather like a citizen of the world. This feeling of not fully belonging either to my old life or my new one is something I share with my participants and it is in many ways similar to the concept of *Hero's Journey* as outlined by Joseph Campbell in his book *Hero With a Thousand Faces*. As Campbell (1988) asserts, “there are two types of [heroic] deed. One is the physical deed, in which the hero performs a courageous act in battle or saves a life. The other kind is the spiritual deed, in which the hero learns to experience the supernatural range of human spiritual life and then comes back with a message. [...] It’s usually a cycle, a going and a returning” (p. 123). The Hero's Journey in many ways resembles the stages of the Rite of Passage. First the individual is separated from her own, familiar world; then she experiences a transformation, where the old ways of thinking and acting are changed or replaced by the new ones; and after the initiate has successfully met the challenges of the initiation, e.g. defeated an actual or a metaphorical monster, such as a great fear, a loss, or an illness, she returns to her own world, bringing a boon or a gift, which usually results in important self-knowledge and which can be used to improve the world in a certain way. As Campbell (1988) states, “You leave the world that you are in and go into a depth or into a distance or up to a height. There you come to what was missing in your consciousness in the world you formerly inhabited. Then comes the problem either of staying with that, and letting the world drop off, or

returning with that boon and trying to hold on to it as you move back into your social world again. That's not an easy thing to do" (p. 129).

The real meaning of the hero's return is to begin to contribute to the society. However, things may not go so smoothly at times—a hero may return with a spiritual of other message and get rejected by her community; she may be ostracized or even eliminated for her ideals which may leave her disillusioned or frustrated; or she may feel that, after her journey and the fundamental change she experienced, she no longer belongs in the world she used to be a part of because the change she underwent is far too great. I believe that the participants in my study and I, in spite of our differences, had some of these issues in common.

Through the process of writing my thesis and by distancing myself to a certain extent from my ancestral culture, I was able to provide a relatively balanced and unbiased report on my findings. On the other hand, I see myself as an interpretive, subjective researcher, and as such I seek to know the situation at hand through the eyes of my respondents. I am still a child of my parents and twenty something years of life immersed in a culture and its beliefs, taboos, and rituals cannot be erased in a mere cosmic blink of an eye, if ever. For that reason, I feel that a great deal of my observations on the matters discussed in this thesis are subjective, which in turn makes this report more qualitative, more personal, and therefore more real.

Regardless of my awareness of the socially constructed nature of human cultural experience, and the fact that in many ways the change I experienced was so great that it made it impossible for me to fully reinstate myself as a member of Serbian community, I

find it hard to completely detach myself from the fabric of culture I came from. As a result of all this, I find myself oscillating between the need for belonging to the culture of my ancestors and reinventing myself within it, and deliberately ostracizing myself from it for the sake of cosmopolitanism, which seems to be closer to my true self at this point in my life. But I am afraid that in the end, I am to be forever trapped in this identity limbo, existing in the vacuum between these two incompatible worlds. Hopefully, this state of the affairs will lead to some equally if not more interesting future research projects in addition to the one presented in this thesis.

As Joseph Campbell asserts, the hero's journey is primarily a journey to the center of one's self, an inner journey to completeness and understanding. My work helped me comprehend and accept my own flawed, peculiar self and subsequently deal with many of my fears and concerns. I can only hope it did the same for each of the brilliant, exceptional women who participated in my study.

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APPENDIX A

The following are my introductory remarks, which I shared with the participants prior to the interview, and my in-depth interview questions:

1. Introducing myself to the interviewee.
2. Stating the purpose of my study.
3. Explaining that the participants were selected on the basis of being women who have had hysterectomies.
4. Explaining about the confidentiality issue (i.e. that I will likely be using quotes from the interviews, but will ensure that no respondent will be identifiable on the basis of names or other identifying characteristics).
5. Assuring the participant(s) that only my advisor and I will have access to the taped interviews and written transcripts that may be created from the tapes and which will be secured in a locked cabinet in my home office for two years after which they will be destroyed.
6. Informing the participants that the interview will last between one and two hours.
7. Informing the participants that there will be no monetary compensation for participating in the study.
8. Informing the participants that they may benefit from this study through expression of their feelings or ideas, gain personal insight, and learn more about the lived experience of hysterectomy.

9. Informing the participants that there are no anticipated emotional problems arising as consequence of participating in this study and that it is highly unlikely that they will be exposed to any risks during this study.
10. Informing the participants that if they feel they need to talk to a psychologist at any time during the study or after the study has been conducted, they will be provided with counseling with Dr. Milica Despotovic, a neuropsychiatrist and psychotherapist, at the earliest convenient time, at no cost.
11. Informing the participants that there are no right or wrong answers.
12. Informing the participants that they can choose not to answer a particular question if it is too uncomfortable.
13. Informing the participants that they can withdraw from the study at any time for any reason without consequences.
14. Asking the participants to read and sign Consent Form if they agree with what is stated there.
15. Informing the participants that they will be given a copy of the consent form for their records.
16. Informing the participants that by signing the Consent Form, they consent to participate in the study.
17. Asking the participants if they have any questions before the interview begins.

In-depth Interview Questions

1. How are women perceived in your culture/community; what are the most prominent female characteristics as defined by your culture/community?

Probe: What is the traditional representation of women in your culture and how do you yourself fit into it?

2. If your own ideas about womanhood differ from the cultural notions you have just described, tell me, in your own terms, what makes a woman what she is?

- 3a. How important is motherhood considered in your culture?

Probe: Did you ever feel pressured to become a mother by your family, friends, or relational partners?

- 3b. What do you think about motherhood?

Probe A: If you are a mother yourself, what were your expectations of motherhood and what is the reality?

Probe B: If you do not have children, how do you feel about not having them?

- 4a. For which medical reasons was your hysterectomy performed?

- 4b. How did you feel physically after the hysterectomy?

Probe: Have you undergone hormonal therapy and what is your experience with it?

5. How has your hysterectomy affected you emotionally?

Probe A: What were your feelings about your own body?

Probe B: How did/have you feel/felt regarding the loss of your menstrual function (period)?

Probe C: How do you feel in regard to inability to conceive or give birth after the hysterectomy?

6. How has your hysterectomy affected your sex life?
7. Are you in a monogamous, committed relationship? If not, what is the current status of your intimate relationship(s)? What was the status of your intimate relationships before the hysterectomy, both in emotional and sexual sense?
8. How has your experience with intimate relationship(s) changed since the surgery?

Probe A: How did your partner behave before, during, and after the procedure?

(For women who were involved before the procedure and remained with the same partner) or Probe B: What was the reaction of your current partner to the fact that you have had a hysterectomy? (For women who had different partners before and after hysterectomy)

VITA

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