

The Effect of Sociocultural Factors on Maternal Short Psychiatric Status and Hyperemesis Gravidarum

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ABSTRACT

OBJECTIVE: This study sought to investigate the associations between Hyperemesis Gravidarum and both sociocultural factors and psychiatric status.

STUDY DESIGN: A prospective non-randomized cohort design was employed. A total of 79 patients with Hyperemesis Gravidarum and 71 healthy pregnant women were enrolled. The study and control groups were compared according to results on the Brief Psychiatric Rating Scale and sociocultural factors specific to the region.

RESULTS: Anxiety, somatic concern, tension, depressive mood, hostility, motor retardation, uncooperativeness and blunted effect were found to be statistically significantly higher in patients with Hyperemesis Gravidarum ($p < 0.01$ and $p < 0.05$). Furthermore, pregnant women living in extended families had statistically higher anxiety scores than those residing in nuclear families ($p < 0.05$).

CONCLUSION: Psychiatric status as well as sociocultural factors specific to the society in which the individuals live should be taken into account in assessments of patients with Hyperemesis Gravidarum.

Keywords: Brief psychiatric rating scale, Extended families, Hyperemesis gravidarum

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Introduction

Hyperemesis gravidarum (HG) is characterized by persistent nausea and vomiting associated with advanced dehydration and metabolic and biochemical problems.¹ A significant endocrine feature of HG is the presence of substantially higher levels of human chorionic gonadotropin. However, the etiology and pathophysiology of the disease have yet to be explained and can comprise psychosocial as well as biological factors.¹ HG is most likely a multifactorial condition and has been associated with many risk factors (such as female infant, ethnicity, maternal psychiatric status, body mass index, socioeconomic status,...)² The prevalence of HG is estimated to be approximately 0.3-2% in United States.^{3,4} In literature, the relationship between HG and psychological factors, including depression and anxiety, has been evaluated in several different studies, with conflicting results.^{5,6}

Individuals in society can be affected, either directly or indirectly, by a range of social, economic, or demographic fac-

tors. For example, the negative effects of socio-economic status and several demographic factors (e.g., job loss, financial difficulties, educational or career problems) on psychological impairment in pregnant women have been reported in previous studies and potential links between these factors and HG have also been examined.⁶⁻¹⁰ However, evaluations of the association between HG and sociocultural factors have thus far been limited. Sociocultural practices such as polygamy and living in extended families, which are frequently seen in the Southeast region of Anatolia, could play a major role in the health and well-being of expectant mothers, as might an unwanted marriage or unplanned pregnancy. Given this context, this study was conducted on pregnant women living in Southeast Anatolia to evaluate the relationship between HG and the psychological status of pregnant women, as well as the effects of sociocultural factors specific to the study population on the development of HG.

Material and Method

This prospective study included females diagnosed with hyperemesis gravidarum who were hospitalized at xxx (.blinded for review). Approval for the study was granted by the Research Ethics Committee of xxx (blinded for review).

The study sample comprised 79 pregnant women with HG (study group) and 71 healthy pregnant women (control group) who were recruited into the study from 17.03.2014 to 10.07.2014. Informed consent form was obtained from each participants. The participants in the study and the control

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groups were matched by age, parity, body mass index (BMI), and gestational weeks at hospital admission. Women with gastrointestinal disease, thyroid disease, gestational trophoblastic disease, psychiatric illness, or any other acute or chronic disease were excluded. Those who had previously received psychiatric treatment were also excluded.

In this study, HG was defined as persistent vomiting in early pregnancy, not due to other causes (e.g., gastroenteritis), requiring any of the following: in-patient admission, day stay with IV fluids, nasogastric feeding (at home or in hospital), or vomiting associated with the loss of 5% of the individual's weight on presentation. Women with oral intake intolerance and ketonuria (i.e., ketone values of 3+ to 4+ as assessed with a urine dipstick test) were hospitalized. A comprehensive medical history was obtained from each participant, and laboratory evaluation tests were applied for renal function, serum electrolytes, and full blood count. A fetal sonogram was also obtained to confirm gestational age.

Data were collected at the time of admission, using a series of forms completed in face-to-face interviews by the same physician (MBS, YC and AG). The patient information form was used to obtain clinical and demographic data related to expectant mothers. Standard inpatient management of HG was carried out, where all patients with HG were initially rehydrated with intravenous fluids and given intravenous antiemetics. Oral intake was resumed based on clinical judgment. Patients were discharged once they were rehydrated and capable of maintaining adequate oral intake.

All of the participants were asked to complete the Brief Psychiatric Rating Scale (BPRS).¹¹ The BPRS evaluation was conducted by a psychologist (AG). A further 6 questions were asked to evaluate sociodemographic characteristics which were felt to be unique to the region. These questions were: "How many concurrent marriages did your father have?", "How many siblings have you got?", "Is your marriage voluntary or unwanted?", "Did you want the pregnancy you currently have?", "What kind of a family do you have? Is it a nuclear or extended family?", and "If you live in a large family, do you feel anxious?". Plural marriage was defined as having a number of equal partners at the same time. Marriages that occurred after divorce or the loss of a partner were not considered plural. A nuclear family was defined as a family unit comprising a couple and their own children, whereas a large extended family, as also consisting of a mother, father, or sibling of the pair.

Statistical analysis was performed using the Number Cruncher Statistical System (NCSS) 2007 and the Power Analysis and Sample Size (PASS) 2008 Statistical Software (Utah, USA). In order to evaluate differences on the BPRS between the two groups, the Mann-Whitney U test was applied. To assess intergroup differences on sociocultural factors, Pearson's Chi-square, Fisher's Exact, and Yates Continuity Correction tests were performed where appropriate, with a statistical significance level of $p = 0.05$ and 0.01 .

Results

A total of 79 pregnant women with HG (study group) and 71 healthy pregnant women (control group) were enrolled in the study. All of the women were unemployed and were primary school graduates. The demographic characteristics of the participants are shown in further detail in Table 1. Approximately 13.3% of the women ($n = 20$) had 6 siblings or fewer, while 86.7% ($n = 130$) had more than 6. The father of the participant was polygamous in 16.7% of cases ($n=25$) and the husband in 3.3% of cases. The living conditions were in a nuclear family for 54% of the women ($n = 81$), and 46% had extended families. Approximately, 20.7% ($n=31$) had unwanted marriages and 75.3% stated that the pregnancy was planned (Table 2).

Table 1: Participant characteristics

Characteristics	Min-Max	M $\pm$ SD
Week	4-14	8.98 $\pm$ 2.3
Gravidity	1-10	3.72 $\pm$ 2.24
Parity	1-8	2.99 $\pm$ 1.71
Abortion	1-4	1.41 $\pm$ 0.74
Cesarean	1-3	1.42 $\pm$ 0.67
Vaginal birth	1-8	3.00 $\pm$ 1.72

M: Mean, SD: Standard deviation

Table 2: Family characteristics of participants

		n	%
Number of siblings	≤ 6 siblings	20	13.3
	> 6 siblings	130	86.7
Polygamous father		25	16.7
Polygamous husband		5	3.3
Family type	Nuclear	81	54.0
	Extended	69	46.0
Voluntary marriage		119	79.3
Voluntary pregnancy		113	75.3

A comparison of the control and study groups did not reveal any statistical differences between the groups in terms of unwanted marriages, unplanned pregnancies, family type, number of siblings, and having a polygamous father or husband. The rate of discontent from living in an extended family was significantly higher among patients with HG ($p<0.01$) (Table 3).

Anxiety, somatic concern, tension, depressive mood, hostility, motor retardation, uncooperativeness, and blunted effect were also found to be significantly higher in patients with HG ($p<0.01$) (Table 4). Pregnant women living in extended families had statistically higher anxiety scores than those living in nuclear families ($p<0.05$) (Table 5).

Table 3: Comparison of demographic characteristics between study and control groups

		Hyperemesis Gravidarum (HG)		P
		HG (+) (n = 79)	HG (-) (n = 71)	
		n (%)	n (%)	
Number of siblings	≤ 6 siblings	12 (15.2)	8 (11.3)	0.642 ^a
	> 6 siblings	67 (84.8)	63 (88.7)	
Polygamous father		14 (17.7)	11 (15.5)	0.884 ^a
Polygamous husband		4 (5.1)	1 (1.4)	0.370 ^b
Family type	Nuclear	37 (46.8)	44 (62.0)	0.063 ^c
	Extended	42 (53.2)	27 (38.0)	
Discontent from living in an extended family		34 (81.0)	9 (33.3)	0.001 ^{a,**}
Voluntary marriage		60 (75.9)	59 (83.1)	0.380 ^a
Voluntary pregnancy		54 (68.4)	59 (83.1)	0.057 ^a

^aYates Continuity Correction, ^bFisher's Exact Test, ^cPearson's Chi-squared, **p < 0.01

Table 4: Comparison of BPRSa scores between study and control groups

	HE (+)		HE (-)		^d p
	Min-Max (Median)	Mean±SD	Min-Max (Median)	Mean±SD	
Somatic concern	0-6 (3)	2.48±1.68	0-4 (1)	1.10±1.21	0.001**
Anxiety	0-5 (4)	3.16±1.80	0-4 (1)	1.07±1.05	0.001**
Emotional Withdrawal	0-5 (0)	0.75±1.29	0-4 (0)	0.44±0.79	0.369
Conceptual Disorganization	0-3 (0)	0.11±0.45	0-0 (0)	0.00±0.00	0.018*
Guilt Feelings	0-4 (0)	0.47±0.97	0-4 (0)	0.55±0.98	0.490
Tension	0-5 (1)	1.39±1.29	0-3 (0)	0.49±0.84	0.001**
Mannerisms and Posturing	0-1 (0)	0.04±0.19	0-2 (0)	0.04±0.26	0.753
Grandiosity	0-2 (0)	0.10±0.34	0-2 (0)	0.07±0.35	0.278
Depressive Mood	0-6 (1)	1.38±1.37	0-5 (0)	0.38±0.96	0.001**
Hostility	0-3 (0)	0.22±0.59	0-1 (0)	0.01±0.12	0.005**
Suspiciousness	0-4 (0)	0.49±1.11	0-6 (0)	0.34±1.05	0.296
Hallucinatory Behavior	0-1 (0)	0.01±0.11	0-0 (0)	0.00±0.00	0.343
Motor Retardation	0-4 (0)	0.53±1.02	0-1 (0)	0.01±0.12	0.001**
Uncooperativeness	0-3 (0)	0.30±0.72	0-2 (0)	0.06±0.29	0.005**
Unusual Thought Content	0-3 (0)	0.09±0.43	0-4 (0)	0.06±0.47	0.224
Blunted Affect	0-4 (0)	0.33±0.78	0-3 (0)	0.06±0.37	0.002**
Excitement	0-5 (0)	0.24±0.91	0-3 (0)	0.04±0.36	0.043*
Disorientation	0-2 (0)	0.03±0.23	0-1 (0)	0.01±0.12	0.947
Total score	0-45 (10)	12.13±8.53	0-31 (3)	4.73±4.77	0.001**

Table 5: Comparison of anxiety scores between study and control groups

	Family type				ap
	Nuclear (n=81)		Extended (n=69)		
	Min-Max (Median)	Ort±SD	Min-Max (Median)	Ort±SD	
Anxiety	0-5 (1.0)	1.79±1.55	0-5 (3.0)	2.62±2.01	0.013*

M: Mean, SD: Standard Deviation, ^aMann-Whitney U Test, *p < 0.05

Discussion

From previous studies, it is not apparent if psychiatric disorders induce HG symptoms or if HG symptoms have a neg-

ative effect on psychiatric status. Moreover, there is also the possibility that these two issues occur independently, but affect each other.¹² In a study by Uguz et al., anxiety and mood disorders were found to be statistically higher among pregnant

women with HG than in healthy controls.¹³ In another study involving Turkish patients with HG, the main findings were that the prevalence rates of psychiatric diagnosis among women in their study population were higher than those in the general population.¹⁴

Several difficulties arise in ascertaining the effects of sociodemographic variables or in assessing the relationship between psychological problems and HG.¹² For example, economic and sociological problems, such as that of unemployment, have been clearly linked to negative psychological outcomes in countries with a low level of economic development, unequal income distributions, or weak unemployment protection systems. However, it is difficult to determine the effects of social traditions and customs on psychological health and wellbeing, due to the difficulty of reaching a reliable source and the lack of clear definitions and classifications concerning these parameters. Different studies have been conducted with regard to the effects of demographic factors on HG. In a previous study in Turkey, patients with HG were evaluated in terms of educational attainment, economic status, and whether or not the pregnancy was planned. In that study, educational attainment was found to be higher in the HG group. No differences existed between the study and control groups in terms of other features, including economic status and whether pregnancies were planned, although anxiety and depression scores were higher in the HG group.¹⁵ In a study conducted in Oslo, being an immigrant was found to be an independent factor, strongly correlated with HG. In that study population, adaptation and other social problems related to migration may have had a negative effect on physical health.¹⁶ In another study in Berlin, researchers reported that immigrant women were 4 to 5 times more likely than native-born women to have HG. At the same time, immigrant pregnant women had longer hospitalization periods for treatment.¹⁷

Socioeconomic factors, such as unemployment, have been shown to negatively affect not only psychiatric status, but also HG symptoms.^{14,18} In the current study, assessment was made of the sociodemographic factors and sociocultural characteristics specific to the region where the study population lived. The study and control groups were both compared in terms of sociodemographic features. The anxiety disorder rate was statistically higher among participants living in extended families than in those residing with nuclear families. Living in an extended family had a negative effect on the women's psychological health and seemed to aggravate HG symptoms. While the extended family type is frequently seen in the region where the study was performed (i.e., Southeast Anatolia), these results suggested that living in an extended family significantly affected the development of HG among the women in this study population. Hence, long-term hospitalization may present a viable option or reasonable approach to treating HG among these patients, as the negative effects of living with the extended family may be alleviated.

Although the planned pregnancy rate was higher in the control group, this difference was not statistically significant. These results suggested that unplanned pregnancies may have a negative effect on maternal perceptions rather than the actual status of health. With further research on an extensive number of patients, the association between unplanned pregnancy and maternal perceptions on psychological status may be more clearly defined. One of the most prominent sociodemographic features of this study population was polygamy. Although the prevalence of this practice has decreased in recent years, it is still relatively frequent and is more common in the urban districts of Southeast Anatolia. Polygamy is a sociological feature that could have negative effects on the psychological status of women in this area.¹⁹ In the current study, there were 4 HG patients and 1 in the control group whose husbands practiced plural marriage. Unfortunately, the effect of polygamy on maternal psychological status and HG could not be statistically evaluated in our study because of the inadequate number of patients in this sample. Another sociological feature of Southeast Anatolia is that of unwanted marriages, which include arranged and/or early marriages. This sociological factor was examined in greater depth in this study, and no statistical differences were observed between HG patients and healthy pregnant women.

This study had several limitations, including the relatively small sample of HG patients and the limited duration of observation. These limitations may have restricted the assessments of relationships between several traditional parameters specific to the study population (e.g., the practice of polygamy) and those of HG. However, to the best of our knowledge, this is the first study to examine sociodemographic factors specific to the region of Southeast Anatolia in pregnant women with HG, and it can be considered to contribute to existing literature on the effects of these significant factors on the development of the condition.

In conclusion, patients with HG should be evaluated in terms of sociodemographic factors, economic status, and family type. Detailed assessments of regional-specific sociodemographic factors are needed, as these factors could have a significant influence on the management of HG symptoms.

Sosyokültürel Faktörlerin Maternal Kısa Psikiyatrik Durum ve Hiperemesis Gravidarum Üzerine Etkisi

ÖZET

AMAÇ: Bu çalışma hiperemesis gravidarum ile sosyokültürel faktörler arasındaki ilişkiyi araştırmaktadır.

GEREÇ VE YÖNTEM: Prospektif nonrandomize yöntem ile 79 hiperemesis gravidarum olan ve 71 sağlıklı gebe karşılaştırıldı. İki grup arasında kısa psikiyatrik durum ölçeği ve bölgeye has olan sosyokültürel faktörler kıyaslandı.

BULGULAR: Anksiyete, somatizasyon, gerginlik, depresyon,

düşmanlık, motor yavaşlama, işbirliği kuramama ve küntleşme Hiperemesis grubunda daha fazla idi ($p<0,01$ ve $p<0,05$). Ayrıca geniş ailede yaşayan gebelerde anksite skorları çekirdek ailede yaşayanlara göre daha fazla idi ($p<0,05$).

SONUÇ: Hiperemesis Gravidarum olan gebeler değerlendirilirken psikiyatrik durumun yanı sıra bölgeye has sosyokültürel faktörler dikkate alınmalıdır.

Anahtar Kelimeler: Geniş aile, Hiperemesis gravidarum, Kısa psikiyatri durum ölçeği

References

- Gadsby R, Barnie-Adshead AM, Jagger C. A prospective study of nausea and vomiting during pregnancy. *Br J Gen Pract* 1993;43:245-8.
- McCarthy FP, Lutonski JE, Greene RA. Hyperemesis gravidarum: current perspectives. *Int J Womens Health* 2014;5;6:719-25.
- Eliakim R, Abulafia O, Sherer DM. Hyperemesis gravidarum: a current review. *Am J Perinatol* 2000;17(4):207-218.
- Ismail SK, Kenny L. Review on hyperemesis gravidarum. *Best Pract Res Clin Gastroenterol* 2007;21(5):755-69.
- Mazzotta P, Stewart D, Atanackovic G, Koren G, Magee LA. Psychosocial morbidity among women with nausea and vomiting of pregnancy: prevalence and association with anti-emetic therapy. *J Psychosom Obstet Gynaecol* 2000;21:129-136.
- Poursharif B, Korst LM, Fejzo MS, MacGibbon KW, Romero R, Goodwin TM. The psychosocial burden of hyperemesis gravidarum. *J Perinatol* 2008;28:176-181.
- Simpson SW, Goodwin TM, Robins SB, Rizzo AA, Howes RA, Buckwalter DK, et al. Psychological factors and hyperemesis gravidarum. *J Womens Health Gend Based Med* 2001;10:471-7.
- Bailit JL. Hyperemesis gravidarum: Epidemiologic findings from a large cohort. *Am J Obstet Gynecol* 2005; 193:811-4.
- Mazzotta P, Stewart D, Atanackovic G, Koren G, Magee LA. Psychosocial morbidity among women with nausea and vomiting of pregnancy: prevalence and association with anti-emetic therapy. *J Psychosom Obstet Gynaecol* 2000;21:129-36.
- McCarthy FP, Khashan AS, North RA, Moss-Morris R, Baker PN, Dekker G, et al. SCOPE Consortium. A prospective cohort study investigating associations between hyperemesis gravidarum and cognitive, behavioural and emotional well-being in pregnancy. *PLoS One* 2011;6(11):e276-78.
- Overall JE, Gorham DE. The brief psychiatric rating scale. *Psychol Rep* 1962;10:799-812.
- Kim DR, Connolly KR, Cristancho P, Zappone M, Weinrieb RM. Psychiatric consultation of patients with hyperemesis gravidarum. *Arch Womens Ment Health* 2009;12:61-7.
- Uguz F, Gezginc K, Kayhan F, Cicek E, Kantarci AH. Is hyperemesis gravidarum associated with mood, anxiety and personality disorders: a case-control study. *Gen Hosp Psychiatry* 2012(4):398-402.
- Annagur BB, Tazegul A, Gunduz S. Do psychiatric disorders continue during pregnancy in women with hyperemesis gravidarum: a prospective study. *Gen Hosp Psychiatry* 2013;35(5):492-6.
- Ezberci I, Guven ES, Ustunur I, Sahin FK, Hocaoglu C. Disability and psychiatric symptoms in hyperemesis gravidarum patients. *Arch Gynecol Obstet* 2014;289:55-60.
- Vilming B, Nesheim BI. Hyperemesis gravidarum in a contemporary population in Oslo. *Acta Obstet Gynecol Scand* 2000;79:640-3.
- David M, Borde T, Siedentopf F. Do immigration and acculturation have an impact on hyperemesis gravidarum? Results of a study in Berlin/Germany. *J Psychosom Obstet Gynaecol* 2012;33:78-84.
- Paul K.I., Moser, K. Unemployment impairs mental health: Meta-analyses. *Journal of Vocational Behavior* 2009;74:264-282.
- Ozkan M, Altindag A, Oto R, Sentunali E. Mental health aspects of Turkish women from polygamous versus monogamous families. *Int J Soc Psychiatry* 2006;52(3): 214-20.