

Women's Experiences with a Pregnancy Complication: Causal Explanations of Hyperemesis Gravidarum

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ABSTRACT. There is a multiplicity of proposed causes, yet a scarcity of research regarding the pregnancy complication, hyperemesis gravidarum (HG), severe nausea and vomiting. This is not unlike other female medical conditions that have been underinvestigated, and perhaps as a result, erroneous assumptions about them persist. This is a report of qualitative findings from a larger study that investigated, in part, illness perspectives of 96 women with HG. Results reveal women view HG as biologically determined and that it has substantial impact on their daily functioning. The study challenges commonly held notions that HG is a psychosomatic disorder.

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Female medical patients, especially those with reproductive disorders, tend to be taken less seriously than their male counterparts. In fact, women's somatic complaints are more likely to be labeled by physicians as psychosomatic both in the presence of organic etiologic factors and when the underlying pathophysiological mechanism of the condition is unknown (Krieger, Rowley, & Herman, 1993; Malterud, 1993; Oakley, 1993; Wallen, Waitzkin, & Stoeckle, 1979). Perhaps because of this, there are a number of medical conditions which have been underinvestigated and where erroneous assumptions about them exist. One such illness is a complication of pregnancy, hyperemesis gravidarum (HG), severe nausea and vomiting of pregnancy. Despite a lack of scientific evidence that substantiates psychogenesis or biogenesis, medicine and related helping professions tend to espouse psychogenic explanations.

This paper reports the qualitative findings from a larger study (Munch, 1998) that investigated, in part, patients' own beliefs about the causal explanation of HG, seriousness of the illness, and impact of the illness upon patients' daily lives. To date, only one other study has examined patients' subjective experiences of HG (Parker, 1997); no documentation exists specifically regarding patients' perceptions about causal explanations of HG. Causal explanations and personal attributions of illness categories can affect patients' own response and others' interactions with patients (Curbow, Andrews, & Burke, 1986). Women's lived experiences with HG that helped to shape their perceptions were analyzed as a first step to giving voice to this patient population.

REVIEW OF THE LITERATURE

Hyperemesis gravidarum occurs when uncomplicated nausea and vomiting of pregnancy become intractable (Starks, 1984). The condition is characterized by symptoms of such severity as to require hospitalization and/or extensive outpatient treatment and includes, but is not limited to, symptoms of dehydration, electrolyte imbalance, and weight loss often greater than 5% of body weight (Abell & Riely, 1992). Like its less severe form, nausea and vomiting of pregnancy (NVP) which is more commonly

known as "morning sickness," HG is a disorder of the first trimester of pregnancy; its onset occurs between the fourth and tenth weeks and typically resolves by the twentieth week, with rare cases persisting well into the second trimester. The typical illness course includes a gradual recovery, frequent relapses, multiple episodes of inpatient management, and/or the use of home health care services, such as intravenous hydration (Cowan, 1996).

HG is a "diagnostic and therapeutic enigma for the obstetrician" (Starks, 1984, p. 253). It remains a puzzling condition for both health care professionals (HCP) and patients because there is no known cause or cure. Prior to the use of intravenous (IV) fluids, HG was a significant factor leading to neurologic disturbance and even maternal death (Cowan, 1996). With advancements in IV fluid therapy, the risk of these outcomes is greatly reduced. Today, health care professionals often view the condition as more of a nuisance. Some contend that patients with HG "garner little attention and engender little sympathy from their physicians" (Abell & Riely, 1992, p. 835). Another factor contributing to this view may be that biological and psychological theories of etiology remain areas of considerable controversy. Although many contend that the etiologic claim of psychosomatic disorder is without any supporting scientific evidence (Callahan, Burnette, DeLawyer, & Brasted, 1986; Majerus, Guze, DeLong, & Robins, 1960; Neri, Levavi, & Ovadia, 1995; Peckham, 1929; Rosen, 1955), the presumption of a psychogenic etiology, at least in part, is pervasive in the literature (Fairweather, 1978; Katon, Ries, Bokan, & Kleinman, 1980-81; Uddenberg, Nilsson, & Almgren, 1971; Walton, 1973).

Theories of psychogenesis have been rooted primarily in psychoanalytic theory. Traditional psychoanalytic theory purports that a pregnant woman's vomiting may represent various intrapsychic conflicts. The pregnant woman's vomiting has been associated with neurotic tendencies (Atlee, 1934), hysteria (Guze, DeLong, Majerus, & Robins, 1959), a rejection of femininity (Menninger, 1939) and as a symbolic rejection—an unconscious, oral attempt at abortion (Chertok, 1972). An ambivalent attitude (versus a marked rejection), representing conflict between wanting and rejecting the baby, also has been implicated (Chertok, 1972). Harvey and Sherfey (1954) implicated sexual frigidity and psychological immaturity in the etiology of HG. Others reported cases in which HG is sometimes manifested as a conversion disorder (El-Mallakh et al., 1990) and is generally believed to be associated with psychopathology (Iancu, Kotler, Spivak, Radwan, & Weizman, 1994). Social psychological theories shifted the paradigm from viewing vomiting of pregnancy as a psychiatric

illness to that of a response to psychosocial stressors such as poverty and marital conflict (Tsoi et al., 1988; Tylden, 1968). Acknowledging the role of psychosocial stressors avoids the view that HG results from the inadequate personality (e.g., immature or ill-prepared for motherhood) of the pregnant woman. However, this position can still be used to support a theory of psychogenesis by suggesting that the etiology is due to the pregnant woman's inability to cope with environmental stress.

The notion of psychogenesis for this diagnostic group is entrenched in the socialization process of health care professionals and patients in Western society. The discourse in current medical textbooks, for example, demonstrates that physicians are still being trained in a model of this illness that does not comport with patients' experiences. The *International Classification of Diseases, Ninth Revision, Clinical Modification* (Practice Management Information Corporation, 1997), which classifies diagnostic categories for hospitalized patients, includes a "psychogenic" subcode for HG. Similarly, as recent as 1998, a social worker providing a lecture to obstetric residents was observed to have said, "Women who have hyperemesis don't want their babies" (A. Myers, personal communication, October 6, 1998). Nadelson and Notman (1990) argued that labeling reproductive disorders and related phenomena psychogenic in the absence of clear data "is a simplistic and reductionistic approach to a complex process. It is supported by the need to resolve ambiguity and maintain an illusion of knowledge" (p. 1). Although the exact cause of HG remains unknown (Anderson, 1994), some contemporary authors have begun to conclude that the etiology is most likely multifactorial and that the manifestation of the illness may differ among patients (Callahan et al., 1986; Cowan, 1996). Still, in their landmark study of gender bias and women's health care, Lennane and Lennane (1973) concluded, "The belief in psychogenesis, once reached, is remarkably persistent" (p. 291).

While it seems illogical to suggest that HG is never impacted by or a result of psychological factors, members of the health care team who presume a psychogenic etiology may discount or minimize the severity of symptoms (Council, 1991), the full impact of the illness on the pregnant woman's quality of life (O'Brien & Naber, 1992), and resort to a variety of punitive attitudes and behaviors toward HG patients (Munch, 1991; Tylden, 1968). These, in turn, may potentially contribute to a less than optimal patient-physician relationship, as well as poor maternal and infant outcomes. Even in the absence of cure, imparting explanations for the illness in a manner that communicates compassion and respect for the dignity, worth, and belief system of the individual may enhance healing (Brody, 1987) and positively influence patients' physiological health out-

comes (Kaplan, Greenfield, & Ware, 1989), and psychological condition (Wolf, Putnam, James, & Stiles, 1978).

In addition, despite its low incidence, with estimates ranging from 1 to 3 cases per 1,000 (Charlin, Borghesi, Hasbun, VonMulenbrock, & Moreno, 1992) to 1 to 10 per 1,000 pregnancies (Katon et al., 1980-81) in the United States and European societies, HG is an expensive obstetric problem frequently characterized by multiple admissions to the high-risk antenatal unit (Godsey & Newman, 1991) and the utilization of medical treatments such as total parenteral nutrition. Moreover, there is some evidence to suggest that women who suffer from severe HG during early pregnancy are more likely to give birth to low birth weight infants (Chin & Lao, 1988), which has implications for costly neonatal and pediatric treatment. Thus, despite technological advancements that have virtually eliminated death from HG, the condition warrants serious attention because of its potentially severe effects both to mother and baby in those in whom it does occur (Callahan et al., 1986).

METHODS

Subjects and Sampling

The setting of this study was a 529-bed tertiary-care hospital that provides both high-risk obstetric and neonatal intensive care services. This regional perinatal center services 13 counties, encompassing both urban and rural settings, and is located in a large midwestern city. The study population consisted of a census of all available patients hospitalized with a primary diagnosis of HG from January 1993 through April 1997 who (a) were currently pregnant and had at least one inpatient hospitalization on the high-risk obstetric unit, but whose HG was resolved and/or (b) had given birth since 1993 and had experienced at least one inpatient hospitalization because of HG during that pregnancy. In cases in which a woman had had more than one HG pregnancy since 1993, the most recent HG pregnancy was the specified unit of investigation. Those eligible for the study were either patients or former patients of this hospital who had no identifiable mental illness, could speak English, were at least 20 years of age at the time of their inpatient hospitalization, and were available by telephone.

The sample is a census of all eligible patients over a 4.5 year period, and was based on theoretical sampling such that the literature supported the research questions and necessitated the study of this population (Strauss, &

Corbin, 1990). The population consisted of 163 patients hospitalized for HG from January 1993 through April 1997. There were 24 not eligible for reasons of age and language. An additional 36 women could not be located due to invalid telephone number, phone disconnection, and the possibilities of relocation, work schedule, and vacation. Of the 103 who were eligible, initial verbal consent was obtained from four women, although the interview did not take place due to scheduling conflicts, and three women declined to participate due to time constraints. Of the 103 women eligible, 96 (93%) participated in the study (59% of all patients hospitalized for HG).

Procedure

Data were collected in a semistructured telephone interview conducted by the author or doctoral-level research assistant. The interviews were based on six open-ended questions, averaging 30 minutes to one hour in length, and were taped and transcribed verbatim. The interview questions focused on patients' beliefs about the etiology of HG, their experiences of the course of the illness, the patient-physician/healthcare provider relationship, and any additional information that respondents desired to share. Respondents were asked to answer interview questions based on their entire HG illness experience, including both inpatient and outpatient medical care. To address interrater reliability, an interview guide and corresponding codebook describing the operational definitions were developed, and the author and research assistant met frequently to debrief the interview process. Demographic and background information were also collected.

The author conducted a thematic analysis of the qualitative data in order to delineate major themes and patterns in the data. Open and axial coding (Strauss & Corbin, 1990) were conducted such that each transcript was analyzed line-by-line, phrase-by-phrase, and word-by-word in the analytic process of naming and categorizing phenomena, subsequently specifying sub-themes that provide the context for themes. In an effort to identify and verify the coding process, the author read the transcripts multiple times, continuously moving back and forth between the coding frame and the data. Refinement of final themes was achieved through this process of constant comparative analysis (Glaser & Strauss, 1967). In this process, similarities and differences in the data were compared and questions were asked about the phenomena reflected in the data until the researcher was reasonably confident that the final coding frame accurately reflected the data. Theoretical saturation of the data was achieved quite early in data analysis, however, be-

cause of the overall purpose of the larger study that included quantitative methods, all 96 respondents were included in the qualitative portion, thereby strengthening the findings (each additional patient reported similar information that lends itself to the salient nature of the analytic themes). An audit trail was employed as one safeguard against investigator bias (Meadows & Morse, 2001). The findings reported here describe 96 women's perceptions of the causal explanation of, and related experiences with, HG.

RESULTS

Characteristics of Respondents

Eighty-three women (86.46%) had already given birth (including 4 pregnancies ending in fetal demise), and 13 (13.54%) were pregnant at the time of the interview. At the time of their HG pregnancy of interest, the study respondents had a mean age of 27.65 years (range, 20-38 years; *SD* 4.23), a median education of some college/no degree, a median employment status of full time, and a median income category of \$30,000 to \$49,999 (range: < \$10,000 to > \$69,999). At that time, 86 (90%) were married, 8 (8%) were single/never married, and 2 (2%) were divorced. Seventy-three (76%) of the respondents were white, 16 (17%) Black/African American, 6 (6%) Hispanic, and 1 (1%) Asian/Pacific Islander.

Analysis of Interviews

The findings reported here describe the most salient themes pertaining to female patients' perceptions of the causal explanations of, and related experiences with, HG.

Causal Explanation

The vast majority of respondents attributed their HG to a physiological cause, such as hormonal changes of pregnancy. Ninety-three of the 96 respondents adamantly voiced beliefs such that their HG "is real," "It wasn't in my mind," "I know it wasn't in my head," and "You don't make yourself throw up blood . . . who would want to do that?" Others explained that their HG occurred in the absence of any life stressors. One woman stated, "I didn't have no marital problems or no problems at work or whatever." Another concluded, "Believe me, when it goes away I feel just fine. . . . I

know it wasn't in my head because it goes away eventually. Nothing changed other than that I'm further along and that I know it's the hormones." Other speculations offered by respondents of possible etiological factors included heredity, gender of the fetus, chromosome anomalies (e.g., Down's syndrome), infertility medications, sperm abnormalities and "nobody really knows the cause."

Although the majority of respondents strongly believed that their particular HG illness was caused by mostly biomedical factors, they were less likely to presume that they knew the cause of HG for women in general. One respondent explained, "In my case I know it wasn't something psychological . . . but I don't know what all could cause hyperemesis. I just know that in my case I think it was just something biological." Respondents were reluctant to generalize from their own experience to other HG women inferring that personal attributions could play a role in the etiology of HG. Many explained that science merely does not know the cause of HG. However, two respondents believed that it is likely that some women tend to be "complainers" and are "looking for sympathy."

The Role of Stress

Although respondents predominately believed in a biomedical cause for their HG, most acknowledged that psychological factors and/or "stress" played a role in their HG experience. The role of stress was described in three ways. First, of the 96 respondents, three reported that life stress was the primary cause of their HG. One attributed her HG to the recent death of her mother. Another believed that numerous life stressors occurring in a relatively short time contributed to her increased physical and psychological vulnerability. The third woman believed her HG was caused primarily by the stress of the physical, emotional, and verbal abuse by her husband.

Second, other respondents refuted the notion that stress was the direct cause of the HG, yet acknowledged that personal problems affected their illness and their ability to cope with the illness. Preexisting life stress was reported as a factor that made the symptoms worse, rather than causing the illness in the first place. One woman explained that her HG pregnancy was considered high-risk after years of infertility and two prior pregnancy losses. Another concurred that the stress of a subsequent pregnancy after experiencing a full-term stillborn affected her HG. She explained:

The main thing was that mine was a very unique situation—for me, anyway. So I think a lot of it was psychological in a way, and a lot of

it was physical, and a lot of it was stress related. . . . I think the more stress you're under, the worse you feel, the more scared you are. But I still think most of it is physical.

In addition, others reported that relationship stress tended to exacerbate their symptoms. For example:

I went with my baby's dad for 20 years, and when I told him I was pregnant he married another girl. He would call me and we would argue, and then I would get sick. . . . I think I would have been sick anyway, but I don't think that helped matters at all.

Third, rather than life stress as a primary cause or a contributing factor of HG, the predominant theme women noted was the belief that the stress they experienced was not the *cause* of HG but was the *result* of the illness itself. That is, the problems associated with a pregnancy complication created stress. Statements such as "I wasn't stressed until I got sick" were expressed. Women described not only the emotional responses common to pregnancy complications, but also the vicious cycle that occurs wherein the physical symptoms and emotional response to the illness become intertwined. The severity and chronicity of the nausea and vomiting associated with HG created emotional responses such as fear and worry about the health of oneself and the unborn baby, sadness and depression, and guilt regarding the effect on partner and children. These reactions, in turn, affected the illness, either by making the symptoms worse or negatively influencing the woman's ability to cope with the symptoms.

Furthermore, the overwhelming response from women was that they were "much sicker" than they ever expected to be and that the HG "lasted longer" than they expected it would. In addition to the physical toll, women noted a variety of ways that HG impacted their lives, reporting that HG interfered with, and negatively affected, their daily lives. They described a plethora of examples regarding the disruptive nature of the illness which goes beyond the scope of this article. Examples include lost wages and lost jobs, inability to provide self-care and/or household responsibilities, children being shuffled among many caregivers, and learning complex home care equipment.

Women reported that they welcomed their physicians' and other HCPs' exploring psychosocial factors that could contribute to the illness; they perceived this as a holistic approach, being treated as a whole person and not merely a medical diagnosis. However, respondents expressed feelings of disappointment, confusion, and anger in instances when HCPs continued to

suspect psychological factors. Ongoing probing and questioning about psychological or stress-related issues was interpreted by some women as suspicion of more than biological factors underlying the illness as well as an added, unnecessary stressor. For example:

I wasn't sure if the doctor thought I was throwing up because of bulimia or something. And I think the doctor was questioning me for that and that made me feel bad because I didn't think I had anything like that. . . . He was questioning me . . . and I am sure it was probably for a good reason, I just felt weird. I heard the question like, am I having emotional problems? I kind of felt like, well, what are you questioning here? This was a planned pregnancy, it was a wanted. . . . This was the first time I had ever been pregnant; [the questions made me feel] kind of dirty or like he thinks I am doing this on purpose.

Another respondent expressed her irritation with what she perceived as the social worker's probing for psychological causes for the HG. She elaborated:

I was irritated because I thought maybe the social worker thought that it could have been prevented if I did this or that. I don't know what she was looking for, but the questions did irritate [my husband and me] . . . and the fact that she thought that it could be psychological, and, therefore, if things were different maybe it could have been prevented.

Respondents also described the stress resultant from the reactions of others. For example, family, friends, and employers often expected women to continue their roles as wife, mother, and employee even in the midst of their illness.

We had only been married 1-1/2 years before I got pregnant. And his family [caused the most stress] because my housework suffered and I wasn't taking care of my husband . . . and his family was having a hard time with that, that it [HG] was a problem. They didn't understand why I couldn't do those things. And we didn't get any help from them.

A lot of other women said that I was making it up, that I couldn't possibly be this sick. In fact, my office called because I couldn't come to work for a couple of weeks and told me that if I wanted

my job I better get back to the office. I came in the next day, and I spent almost all day in the bathroom; and they finally understood that I was not lying.

As far as other women in the public and other people, they think it's all in your head, and they don't understand why you're so sick. Because they weren't sick, they think you're just weak.

Referral to Psychosocial Resources

The psychosocial toll that the illness placed on women and their families led respondents to acknowledge the benefits of support groups, professional counseling, and programs that link women who have previously experienced HG with new patients; some expressed frustration when resource information was not provided. One woman described how helpful it was for her physician to share her belief that stress did not cause her HG but that HG created the stress. Her physician proactively raised the issue of illness-related stressors and offered psychosocial referral information. In so doing, he validated the psychological and emotional impact of HG, yet he did not imply that HG was caused by an inability to cope with stress. She explained:

I remember he would be very supportive in the fact that it was mentally draining and that there was help available if I needed someone to talk to, help relieve some of the depression caused by hyperemesis. The hyperemesis was not caused by the depression, it was the reversal, it was caused the other way around. You know, you are very isolated and you are sick of being stuck with needles and missing your children and everything. So he was very supportive and understanding, and recognized things that even I was slow to bring up.

DISCUSSION AND IMPLICATIONS

The qualitative, retrospective nature of this study has characteristics that may affect the generalizability of the results. Although this study is not generalizable beyond the population in this setting, the data generated provides information useful for future studies about HG. Research designs that provide broader generalizability of findings could prove beneficial for affirmation of these data. The qualitative findings have given

voice to a group of women who are seldom asked about their experiences with HG and have offered their anecdotal evidence for consideration by health professionals.

The results presented in this article reveal two main conclusions. First, the majority of respondents felt their HG was biologically determined and not "all in their head." Moreover, respondents (a) voiced confusion, frustration, and anger in situations which a psychogenic etiology was suggested or implied by their physicians, other HCPs, and/or their loved ones; (b) expected HCPs to view HG as serious enough to warrant medical intervention, and to believe their accounts of their symptoms; and (c) expected an understanding and compassionate approach by HCPs. Second, results demonstrate that HG had substantial impact upon the respondents functioning in the paid work force and in their lives with their children and families.

The finding that some women were expected by others to continue their roles as wife, mother and employee despite a debilitating illness warrants discussion. It is possible that these unrealistic expectations are, in part, due to another pattern that is reflected in the women's narratives. There was a pattern pertaining to the perception that pregnancy is not an "illness"; pregnant women are not "ill" women. While this may be a healthy attitude, in general, it places an undue burden on women suffering from HG. That is, they are seen as women encountering normal physiological symptoms associated with pregnancy and should merely "deal with it." This pattern was noted with regard to doctors, HCPs, and, to some extent, the patients themselves, although lay people were noted as most susceptible to this belief.

This finding is consistent with studies of NVP suggesting that the validity of symptoms is challenged by family, friends, and caregivers (O'Brien & Naber, 1992). Perhaps this is because NVP is the most common and well-documented physical symptom of early pregnancy, and HG resembles NVP. The medicalization of pregnancy—viewing pregnancy and the associated phenomenon as disease—has certainly posed problems for women's health care (Rothman, 1991; Scully, 1994). However, NVP in its most extreme and complicated form, HG, goes beyond "normalcy" and requires validation and subsequent medical intervention. Respondents in this study clearly reported greater satisfaction when HCPs viewed the intensity of their symptoms as serious and took action, versus a nuisance that must be merely tolerated as a normal occurrence of pregnancy. Furthermore, respondents reiterated throughout the interviews the importance of health care provider support and the necessity of physicians, in particular, verifying the illness as HG (vs. NVP) and as "real." This "ex-

pert power" (Todd, 1989) was essential in validating the illness to family members and to the social world. This finding is consistent with scholarly works advocating the value of professional support as an important form of social support (Crnic, Greenberg, & Slough, 1986).

Respondents' recommendations that referral information be given to patients regarding the hospital social worker, outpatient counseling and support group services was a theme that emerged from the data regarding ancillary psychosocial support services. As the data in this and other studies (Waitzkin, 1991) have shown, problems arising from and affected by illness must be addressed as they are deemed important to patients. Physicians' attention, in particular, to the psychosocial aspects of HG becomes even more imperative as recent advancements in medical technology have shifted the care of HG patients from inpatient hospitalization to home health care. For some HG patients, arrangements for home IV therapy can be made from the physician's office and/or the emergency room, without the patient ever being hospitalized. Despite the benefits of home health care services, patients will be less likely to come into contact with other HG patients. It is imperative that physicians and their office staff be aware of, and refer homebound patients to, local professional and lay support programs, and home health social workers.

Finally, the results support the importance of interdisciplinary collaboration with physicians (Abramson & Mizrahi, 1996) such that understanding women's illness perspectives and factors influencing patient satisfaction can help social workers contribute to patients' health, as well as impact organizations and other HCPs (Hsieh & Kagle, 1991). The findings can assist social workers as they participate in physician education (Hunsdon & Clark, 1984; Zayas & Dyche, 1992) and social work education in clinical and academic settings. Social work, medicine and nursing students desperately need education not only about physical and psychosocial aspects of women's health and illness, but also the impact of sociocultural, historical and epistemological factors that shape social constructions of HG (Munch, *in press*) and other female medical conditions (e.g., premenstrual symptoms, chronic fatigue syndrome, fibromyalgia). Additionally, understanding women's experiences of HG can help social workers and members of the health care team to intervene more effectively with patients and their families, addressing issues related to the psychosocial adaptation to illness. Results of this study can assist social workers, along with their medical and nursing colleagues, in reconsidering their ideologies about HG patients, thereby challenging erroneous and gender-biased assumptions about women patients that permeate the literature. A reevaluation of the ways in which a health care professional's interaction with HG patients may, in and of it-

self, be a psychosocial stressor that contributes to exacerbating symptoms and impeding recovery will be valuable in promoting better patient care (Munch, 2000). Study results indicate a need to revisit women's experiences with reproductive illnesses that have been underexplored.

CONCLUSION

Descriptive articles and research designs examining psychological predictors have typically presumed that HG is a psychosomatic disorder (Iancu et al., 1994; Novey & Goodhand, 1938; Tsoi, Chin, & Chang, 1988). It is not surprising, however, to find that the data support a relationship between psychosocial indicators and HG. The qualitative data in this study also demonstrated that the two coexist. Most women diagnosed with pregnancy complications experience considerable stressors common to and resulting from the pregnancy complication itself (Aboudi & Zager, 1995; Yali & Lobel, 1999). However, unlike previous studies, the temporal relationship of psychological factors/stress became more clear in this study. The qualitative data suggested that although psychological factors/stress may be primary contributors to HG, it is equally plausible (and the experience of the majority of women in this study) that HG caused the stress and psychological distress. Previous studies have overlooked this equally logical conclusion. Reframing the question about the temporal relationship between stress and HG is important in altering the misperception that HG is primarily a psychogenic illness. Merely looking for psychological predictors tends to frame the question as an intrapsychic problem—a matter of the patient's supposed dysfunctional personality or poor coping. Moreover, HG is not unlike other medical conditions in which the "debate within the literature . . . tends to be premised on the dichotomous construction of either psychogenic or organic etiology." (Hart & Grace, 2000, p. 190). The persistence of the outmoded mind-body dualism may diminish as we acknowledge a biopsychosocial model of illness rather than presuming a psychological etiology of HG based on erroneous assumptions.

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