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HYPEREMESIS GRAVIDARUM AS A PSYCHOSOMATIC DISORDER

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Hyperemesis gravidarum (HG) is a pathology that occurs during pregnancy. According to Grooten et al (2015), it affects between 0.3 and 1% of the population. Its main symptoms are nausea, intense vomiting, loss of body weight and dehydration, in addition to hydroelectrolytic disorders and nutritional deficiency, as discussed by Alfenas et al (2017). This pathology usually appears between the fourth and tenth week of pregnancy, and, according to Ismail and Kenny (2007), this condition can be aggravated and trigger preeclampsia, a premature detachment of the placenta, with direct consequences for pregnancy, such as occurrence of stillbirth and birth at low gestational age.

In this sense, Kramer et al (2013, p. 2) observe that:

> The condition of malnutrition and vitamin deficiency in GH can also complicate diseases such as anemia and peripheral neuropathies and, in rarer but extremely serious cases, when not promptly corrected, it can progress to Wernicke's encephalopathy and central pontine myelinolysis. In addition to the possibility of trauma to the esophagus, such as Mallory-Weiss disease due to prolonged vomiting.

In addition, depression and anxiety are the psychological factors most associated with GH and can cause negative impacts during and after pregnancy, such as miscarriage, fear of future pregnancies, in addition to the possibility of affecting the woman's commitment to her offspring, according to the authors. Alfenas et al (2017). Also, according to Tan et al (2014), in some cases, women may be unable to perform daily activities and even quit their jobs.

Scholars in the area in focus, such as Tachibana et al (2006) and Alfenas et al. (2017), warn about the strong lack of research on GH, because "although the concept of hyperemesis gravidarum is very clear, it is clear, however, that the literature on the subject is still scarce" (TACHIBANA et al; 2006), p. 2). Another relevant point presented by the aforementioned authors concerns the negligence of the medical team towards the patients affected by the syndrome in question.

There is still no consensus regarding the etiology(s) of GH, a reality that serves as an impasse for advances in its study and treatment. In this sense, some authors, such as Munch (2002) and Barbosa (2012), point to a relationship between GH and certain mental/ psychic processes, a thesis that has been gaining prominence associated with aspects of a genetic and endocrine nature.

In addition, Munsh (2002, apud ALFENAS, 2017, p. 2) indicates that "the growing integration between medicine and knowledge from the human sciences has allowed a treatment that meets biological, social and psychological issues". Therefore, we can see the defense of a multidisciplinary approach to act on GH, because only this way would it be possible to provide the best diagnosis and treatment for the patient.

Contrary to a broader proposal, such as the multidisciplinary one, GH is seen, in some cases, as purely organic, hormonal and genetic. However, there is no research that proves its purely physiological character. Therefore, our study focused on the understanding of GH as a possibility of psychosomatic manifestation during pregnancy, a period responsible for mobilizing many affections and psychic tensions.

According to Chiozza et al (1987 apud BARBOSA, 2012, p. 476), the somatization process basically consists of the manifestation of conflicts, anxieties and affections through bodily symptoms. Illness occurs in an attempt to hide from the subject a story whose meaning he cannot bear, thus having an outlet for the body. In other words, getting sick can be a symbolic response that

unconsciously seeks to change the meaning of the story and/or its outcome.

Ferraz et al (2007, apud BARBOSA, 2012, p. 476) advocate that the forms of neurotic defenses linked to the formation of representations and the field of the symbolic give rise to pre-symbolic somatic manifestations. Consequently, the body is the privileged setting for them to occur. These same authors also argue that anxiety, present in 36.5% of patients with GH (UGUZ, et al. 2012), is a basic energy that generates psychosomatic symptoms and, due to its unconscious nature, seeks the path of expression. body.

Another relevant point is that the digestive system tends to show signs and symptoms caused by emotional and metabolic changes, but which are also caused, above all, by psychological conflicts (LUI and FREDDI; 1979). In this sense, tension and unresolved conflicts in relation to motherhood cause anxiety, which, if very intense and prolonged, tends to drain into the body and affect physiological functions.

It is known that every human being somatizes some of their conflicts. However, there are periods when, due to intense changes, as in the case of pregnancy, this is more present, since this process is loaded with bodily and affective changes. Based on this, we formulated our research proposal aimed at understanding HG as a possible psychosomatic manifestation.

METHOD

We set out to carry out a fundamentally theoretical research, with clinical contributions from interviews with health professionals with experience in monitoring patients diagnosed with GH. This research had an exploratory character, since it consisted of collecting data from the literature on the themes: HG; psychosomatization from the point of view of psychoanalysis; perinatal psychology and psychic health of pregnant women.

We carried out a survey in the medical literature of studies on GH, contextualizing it in the field of gynecology and obstetrics, as well as studies on psychosomatic phenomena. In the psychoanalytic literature, we focus on the phenomenon of gestating and having a child, on the psychic consequences for women, as well as studying the understanding of psychoanalysis about the psychosomatic phenomenon and its approximations with GH.

In the interest of comparing what is in the literature and the effective practice of monitoring pregnant women with GH, we conducted interviews with health professionals in order to broaden the understanding of this pathology. In the interviews, the points addressed were:

Diagnostic criteria; HG classification; existence of psychological factors in GH; HG as a psychosomatic disorder; predominant age group of pregnant women; predominant condition of pregnancy (primigravid, second or multiparous); physical characteristics of pregnant women; presence of family conflicts; associated disorders; triggering factors of motion sickness; desired pregnancy or not; previous abortions; postpartum condition; support network; socioeconomic status and the presence of multidisciplinary care.

Professionals were selected mostly through social media and, in some cases, by referral. The criteria used were: i) to have a degree in one of the following areas: Nutrition, Psychology, Gynecology and Obstetrics and in Nursing or Tech. of Nursing, and ii) have experience in caring for pregnant women with GH. Thus, we conduct interviews in person and on videoconferencing platforms. The interviewees were: three obstetrician-gynecologists, four psychologists, three nutritionists and three nursing professionals.

The testimonies collected, if, on the one hand, corroborated the way the literature has characterized GH, on the other hand, they presented more richness of details for the understanding of this pathology, as we will see in the results and discussion.

RESULTS AND DISCUSSION

Following the proposed methodology, we started our research activity with theoretical studies distinguishing two areas: a) what medicine and classification manuals such as the International Classification of Diseases (ICD 10) and the Diagnostic and Statistical Manual of Mental Disorders (DSM V) say about HG and psychosomatics?

b) what the field of psychoanalysis says about psychosomatics and HG. to the search

We used the following keywords in Google Scholar and Pepsic: "Psychosomatic", "Psychosomatic", "Psychosomatic and Psychoanalysis", "Psychosomatic and Psychoanalysis", "Representation and Psychoanalysis", "Hyperêmesis Gravidarum", "Hyperêmesis Gravidarum and psychoanalysis", "Hyperemesis gravidarum", "Hyperemesis Gravidarum and Psychosomatic", "Hyperemesis Gravidarum and Psychosomatic", "Hyperemesis Gravidarum and Psicologia", "Gestation and psychosomatic", "Gestation and psychosomatic", "Hyperemesis gravidarum", "Psychosomatic and Hiperemesis gravidarum" and "Psychosomatic and pregnancy".

Thus, we could see that the meaning of psychosomatic in medical literature is conceptually similar to psychoanalytic psychosomatics, but is structurally different from it. The medical definition generally corresponds to what belongs to both the body and the psyche, a thesis accepted by psychoanalysis, elaborated, however, from its theoretical assumptions.

Currently, the DSM V talks about a Somatroform Disorder, while ICD 10 refers to a Somatization Disorder. It is worth mentioning that the DSM V classifies conversion disorders as somatoform, whereas the ICD 10 makes a division between somatization disorder and dissociative (conversion) disorders.

In view of this, it can be said that, for psychoanalysis, the ICD classification would be the most appropriate, since the conversion mechanism structurally differs from the psychosomatic one, since:

> Unlike a conversion symptom, a phenomenon is said to be psychosomatic when the symptoms are not inscribed in the hysterical (symbolic) body, but in the medical (organic) body, demanding interventions, responses and explanations to the pathophysiology. (WINOGRAD and TEIXEIRA, 2011, p. 176).

The concept of psychosomatics in psychoanalysis is constructed from the representation process. The subject who psychosomatizes does so because he cannot get a certain event to be represented or symbolically inscribed in the psychic apparatus, causing the unrepresented to flow directly into the body. Based on this, we articulated studies on GH as a possibility of manifestation of the psychosomatic phenomenon. We deal with this relationship considering the current literature on GH and the professionals' testimonies. In addition, we have prepared response categorization tables according to their areas of expertise and the topics exposed in the methodology (see tables II, III, IV, V in annexes).

Regarding the interviewees, there is variation in the number of patients seen by professionals, according to the length of career of each one and the specificity of the work sector within the hospitals.

We understand that the problem of desire at HG is not a simple equation. Saying that "hyperemesis gravidarum is caused by the mother's rejection of the baby" is not always true. We agree with Tachibanna et al (2006,

p. 3) when they observe that "the existing psychological factors must be carefully considered, and one must not fall into the easy and misleading explanation, in which the symptom would be the seal of a little understood, but famous, fetal rejection.

However, analyzing the psychoanalytic literature on GH, it seems to be closely related to the issue of desire, to the place that the child occupies in the mother's imagination, to the baby's hyper-idealization and the abrupt rupture of this idealization, or even to non-idealization. However, the problem of desire and the symbolic place that the baby occupies is not restricted to the dyadic mother-baby relationship, but expands to the mother-baby relationship with the world.

Many professionals spoke about these women's fear of how they and the pregnancy would be seen by family members, the child's father and the community. That is, if she will be accepted as an object of desire of the other. Despite this, understanding the problem of desire for Lacan, according to Lustoza (2006), we cannot segment it: that of the pregnant woman for the baby and that of the other for her and the baby.

And alsl about the issue of desire, a point raised in the interviews was the ambivalence of the desire to be a mother and the desire to gestate. We cannot ignore that GH is a pathology of the first trimester of pregnancy, even if it can be postponed, which coincides with what Maldonado (1997) says about the first trimester of pregnancy being characterized by the ambiguity of the desire to be pregnant.

We also know that pregnancy is a moment of extreme vulnerability, in which the mother normally identifies with the baby, so that she can provide the essential care for the baby's development, as Winnicott (1958) defends, when postulating his concept of primary maternal concern. The pregnant woman, also, in this regressive movement, may feel the need to be cared for by her own mother.

We defend, then, the possibility that the pregnant woman, when rejected, helpless, can become fixated on this identification with this intrauterine baby and be unable to elaborate the experiences of her own gestating and beyond it. Anguish, one of the affections presented by pregnant women with GH, reveals the non-autonomy of the subject, a subject who is prevented from responding to another, whose desire is is enigmatic. In this context, the meaning of psychosomatic comes in, when the subject becomes unable to represent the sensations experienced, and these drain into the body (MARTY, 1998) – in this case, through exacerbated nausea and vomiting.

From this, we can also discuss expressive points in the interviews about maternal guilt, the fear of losing the baby, the pregnant woman's feeling of killing this baby and the concern about her future care. These can be analyzed through the concept of primary maternal concern, but also as a reflection of a possible compensation for an initial rejection of this baby. Some interviews brought pregnant women with GH as "hyper desired", establishing a relationship, at first sight, of opposition with those who were rejected. However, pregnancies were always placed in these extreme places, generators of stress, for example women who underwent multiple medical procedures to get pregnant and who, when pregnant, continually question themselves if they will be able to exercise motherhood.

The diversity of answers regarding the classification of GH indicates the different understandings of professionals about its nature, but also indicates the lack of knowledge of the notions of syndrome, disorder, illness and disease. One of the doctors, for example, preferred to refer to the HQ as a "frame" instead

of the above notions, justifying that this term is milder for pregnant women. The way each professional classifies it can have negative and positive consequences, softening or making GH more complex. We chose to classify it as "disorder" in an attempt to characterize GH as a psychosomatic manifestation, also because the literature, like classification manuals, always refers to "psychosomatic disorder".

The diagnostic criteria were more uniform than the classification of HG, however, even so, they were not always clear, especially in relation to the period and duration of the manifestation of HG. On the other hand, it is a consensus that HG is treated as a pathology. Some professionals emphasized the importance of early diagnosis as a way of avoiding the worsening of symptoms or their postponement, as well as initiating the prevention of complications that may occur, as mentioned in the introduction.

None of the health professionals brought important associations, in their clinical practice, of GH with mood disorders during pregnancy, among other comorbidities, even when they were deliberately asked about it. There was no prevalence of age or parity among the interviewees' patients, as well as the occurrence of previous abortions. Postpartum complications such as postpartum depression, breastfeeding problems, difficulties in mother-infant bonding, baby blues, anxiety disorders, post-traumatic stress disorder and puerperal psychosis have been reported.

Professionals, according to the literature, consider hormonal factors relevant for the onset of GH, as well as believe that psychological factors can also interfere with the condition. Some interviewees also consider that psychological factors are more visible in cases where the condition fluctuates, that is, when symptoms improve and then relapse. Others stated that only when symptoms remain after the end of the first trimester can it be said that GH is related to psychological factors. Usually, emotional factors were seen as triggers for the worsening of the condition, and few respondents believe that GH can be caused only by psychological factors. Other emotional factors associated with this were: anxiety, fear, anger, frustration, insecurity, sadness, feeling of inadequacy and abnormality and shame.

We realized that the need that many have to defend the purely physiological character of GH may be related to the treatment that society gives to people with psychological problems. These are read as unwillingness to improve, freshness and victimhood. In this regard, we can also question whether structural machismo would not be behind this idea, since symptoms that are related to the female sexual apparatus are often understood as not important, with society desensitizing to the pain experienced only by women.

Both in the literature and in the interviews, the psychosomatic character of GH appears; although not always explicit, but by the emphasis on psychological aspects. Some tend to minimize the presence of the psychic in the body, believing that this would delegitimize the reality of the condition and the patient's pain, which may be related to a common social conception that what belongs to the psychic order is not real. In addition, there is a difficulty in understanding the psychosomatic dimension of the condition, precisely because of the difficulty in unifying body and mind, which is why, when asked directly about the psychosomatic character of GH, professionals expressed some confusion about its meaning, often understanding it as something merely of a psychological order. For some of them, understanding HG also from a psychic point of view would lead them to renounce or neglect the medical treatment of the body.

The feelings of anger and anxiety experienced by pregnant women, often

mentioned by the interviewees, have also been reported in articles about other pathologies considered psychosomatic, such as bruxism and some gastropathies (GURGEL, 2007), (SERRALTA and FREITAS, 2002).

Other traits identified by professionals with regard to the profile of pregnant women were perfectionism and control, usually linked to the objective of not feeling frustrated.

Besides, the discursive rigidity was pointed out by some health professionals as a characteristic of the patients' discourse. It is important here to talk about Pierre Marty's theory of mentalization (1998). The author argued that patients with psychosomatic illnesses had a discursive poverty, not being able to fantasize and represent their experiences. The narrative was merely descriptive. This is a consequence of what Pierre Marty (1998) calls operative thinking. In view of this, some interviewees reported that these patients did not fantasize about the baby or about the existence of a second person, usually the mother, with whom the patient could talk about the pregnancy and the symptoms, and the pregnant woman was not allowed to express herself directly, that could give meaning to what I was feeling. At the same time, one of the psychologists reported that her patient fantasized about the baby and considered him as a baby with a divine mission, thus connoting a certain dissociation relative to the real baby.

Another point highlighted by the professionals was the presence of family conflicts and a short or fragile support network, where the patients felt abandoned by their partners and relatives. Often, the mother, as well as the partner, rejected the pregnancy and belittled the HG, which reinforces the problem of the other's desire.

Corroborating what Tachibana et al (2006) discussed about the symbolic place of the hospital for patients with GH, some professionals commented that the hospital becomes a place where the patient can get away from the stressful and conflicting environment, offering her, in addition, care and reception.

The literature on GH points out how this disorder affects women also in relation to their profession (TAN et al, 2014), often making it impossible for them to work. There seems to be no distinction of economic class among women affected by GH, however many low-income women cannot have a variety of foods, nor have several meals, in addition to not having someone to prepare food for them. Due to HG starting in the first trimester of pregnancy, when they are still working, they do not have time to eat meals at specific times and with intervals that could help them to reduce nausea. In short, they don't have the basics to feel minimally comfortable.

Another important aspect, which could facilitate assistance to these women, is multidisciplinary care. Professionals indicated that most do not have access to it, as well as not have access to the necessary information about HG.

CONCLUSION

The purpose of this research was to understand GH as one of the possible psychosomatic manifestations. Thus, we found, in the literature and in the professionals' statements, that the psychosomatic aspect in GH may be related to the issue of desire, but it is not necessarily related to the mother's rejection of the baby, as some try to postulate. Observing the data obtained in the research, we found that patients with GH are usually experiencing relevant family conflicts and have a weakened support network, in addition to experiencing other stressful situations. Manifestations of anxiety, fear, anger, frustration, insecurity, sadness and shame are frequent among these

women, and these feelings may be associated with desires that could not be signified, many of which could not even be represented because they were archaic. and go back to the primeval relations with the mother. In this context, and considering that, in the psychoanalytic perspective, the boundary between body and psyche is tenuous, this justifies the presence of psychosomatic phenomena. That is, the pregnant woman cannot represent or symbolically inscribe in the psychic apparatus certain sensitive experiences, such as those caused by family conflicts related to pregnancy, ambivalence in relation to pregnancy and the desire to be a mother, or even stressful situations not directly linked to pregnancy. This, therefore, causes what was not represented to manifest itself in the body through vomiting and exacerbated nausea.

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