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Frequency, Severity and Effect on Life of Physical Symptoms Experienced during Pregnancy

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Précis: Higher frequency, severity of discomfort and effect of physical symptoms on life predicted psychopathology in the second trimester of pregnancy.

Abstract
This study aimed to (1) describe the number, frequency, severity of discomfort and effect of symptoms on life of 29 physical symptoms women experienced at 15-25 weeks gestation; (2) to explore whether experiencing this group of physical symptoms more frequently and intensely was associated with a higher score of depressive symptoms and lower self-esteem; (3) to examine whether discomfort and effect ratings aided prediction of wellbeing over and above symptom frequency; and (4) to investigate which individual physical symptoms contributed most to predicting depressive symptoms and self-esteem. Pregnant women (n=215) completed the Beck Depression Inventory, Rosenberg Self-esteem Scale and a physical symptoms questionnaire. Frequency, discomfort, and the effect of physical symptoms all consistently correlated with higher scores for depressive symptoms, but less consistently with lower self-esteem. Discomfort and the effect of symptoms predicted variance in depressive symptoms after accounting for symptom frequency. Higher frequency, more discomfort and the effect of fatigue and effect of flatulence were related to depressive symptoms. Relationships between pregnancy-related physical symptoms, depressive symptoms, and low self-esteem suggest that when women report any of these constellation of factors, further screening is indicated. A comprehensive assessment of physical symptoms includes frequency, discomfort and effect on life.

Key words: pregnant women, signs and symptoms, self concept, depression
Pregnancy is often viewed as a time of excitement, anticipation and uncertainty\(^1\); however, it is also characterized by significant changes in the functioning of a women’s body.\(^2\) The physical changes accompanying pregnancy affect all major body systems\(^3\) and are commonly expressed as physical symptoms. Pregnancy-related physical symptoms range from nausea, vomiting and heartburn, to leg cramps, haemorrhoids, and shortness of breath,\(^4\) many of which can be experienced as unpleasant and having potentially negative effects on a woman’s life.

Cancer and chronic pain research consistently show a positive relationship between physical symptoms and depressive symptoms.\(^5,6,7\) While the direction of effect is not always clear (i.e., depression may exacerbate physical symptoms, or physical symptoms may cause depression), some studies suggest that unpleasant physical symptoms may increase depressive symptomatology,\(^7\) possibly because they interfere with life functioning. For this reason it is important to examine whether pregnancy-related physical symptoms are also associated with lesser psychological well being.

Understanding factors that may contribute to depressive symptoms is especially significant in pregnancy since the negative consequences of depressive symptomatology include low birth weight, premature delivery, poor prenatal care, and substance misuse.\(^8\) Undetected, untreated antenatal depression is the strongest predictor of postnatal depression\(^9\) which can cause psychological problems for both mother and child.\(^10,11\) Low self-esteem during pregnancy has also been shown to be related to body dissatisfaction.\(^12,13\)

A search of the psychological literature (PsychINFO and PubMed databases) resulted in only four studies that explored the relationship between pregnancy physical symptoms and general psychopathology.\(^4,14,15,16\) A higher frequency of physical symptoms has been shown to be associated with depressive symptoms in three studies\(^14,15,16\) supporting this link, and with lower self-esteem in one study\(^9\) suggesting the possibility that esteem may be affected by physical symptoms as well. However, most of these studies were limited in various ways: in one study data were retrospective with women reporting about the full pregnancy when they were in late pregnancy timepoint,\(^4\) in another few physical symptoms were explored (i.e., only nausea, fatigue and vomiting),\(^14\) and in most cases only the number and frequency of symptoms were measured without indicating whether severity of discomfort or effect on life of symptoms related to greater psychopathology.\(^4,14,15\) Severity of discomfort or distress caused by symptoms\(^17\) and the effect of symptoms on quality of life\(^18\) have been shown in cancer research to enhance understanding of subjective experiences of physical symptoms, and are therefore potentially also important to assess. The one study to include these extra dimensions\(^16\) only examined a composite measure of symptoms, summing number, frequency, severity of discomfort and effect on life of physical symptoms; but did
not examine which individual symptoms or dimensions had the strongest relationships with well-being.

The current study, therefore, had four aims, with a sample of women who were 15 to 25 weeks gestation. First, we wanted to describe the physical symptoms women experienced during the second trimester more comprehensively, examining a large range of symptoms, and assessing them in terms of number, frequency, severity of discomfort (discomfort) and effect of symptoms on life (effect). Second, we explored whether experiencing this combined group of physical symptoms more frequently and/or intensely (in terms of discomfort and effect on life) was associated with higher scores of depressive symptoms and lower self-esteem. Third, we examined cross-sectionally whether discomfort and effect-on-life ratings contributed to the statistical prediction of psychological wellbeing over and above the frequency of experiencing the symptoms, which would point to the importance of assessing these extra dimensions in clinical settings. Finally, we investigated which individual physical symptoms contributed most to predicting depressive symptoms and self-esteem. Overall, consistent with a conceptualisation of physical symptoms affecting well being, we expected physical symptoms to be significantly associated with depressive symptomatology due to the state-dependent nature of depression\(^\text{19}\), whereas we expected physical symptoms to be less predictive of self-esteem which is a more stable personality variable.\(^\text{20}\)

**METHODS**

This self-report questionnaire study involved data being collected during one timepoint at late first/early second trimester during pregnancy. Following obtaining university ethics approval, pregnant women (currently 12 to 17 weeks pregnant) were recruited for a health and wellbeing study, “Your Experiences During Pregnancy”\(^\text{21}\), using flyers/advertisements placed at obstetricians’ waiting rooms, prenatal exercise class venues, in a university newsletter, and through direct recruitment at relevant Mother, Child, and Baby shows. Only women who responded to the advertisements were sent a number-coded questionnaire package (for confidentiality), which included a reply-paid, self-addressed envelope for the return of their completed questionnaires, and a separate reply-paid, self-addressed envelope for the return of the signed statement of informed consent.

The demographic information collected included the participants age, marital status, education level, occupation, and annual income. The short version of the *Beck Depression Inventory*\(^\text{22,23}\), that has demonstrated construct validity\(^\text{23}\), concurrent validity\(^\text{24}\) and good internal consistency\(^\text{25}\), was used to measure depressive symptoms; total score of 0-3 is non-depressed; 4-7 is mild; 8-15 is moderate; and 16+ is severe\(^\text{22,23}\). The Beck Depression Inventory long and short versions correlate .89 to .97\(^\text{23}\) and the long version has been validated for use in the pregnant
population\textsuperscript{26}. Twelve of the 13 items of the Beck Depression Inventory (excluding an item relating to suicide due to Ethics Committee considerations) were used in the present study. Cronbach’s $\alpha$ in the current sample was .83.

The \textit{Rosenberg Self-Esteem Scale}, used to measure self-esteem,\textsuperscript{27} is a widely-used measure that has yielded good internal consistency, stability and validity of scores.\textsuperscript{28} The Rosenberg Self-Esteem Scale has demonstrated good internal consistency in a pregnant sample\textsuperscript{16}. In the current sample Cronbach’s $\alpha$ was .88.

Wallace et al.\textsuperscript{4} listed 29 pregnancy-related physical symptoms in their physical symptom questionnaire which were used in this study to measure physical symptoms. Consistent with Wallace et al., women rated the frequency of experiencing each symptom (0=never, 1=rarely, 2=sometimes, 3=very often). A pregnancy study\textsuperscript{12} using a sum total of symptom scores yielded a Cronbach’s alpha of .85. We created two additional rating scales: severity of discomfort caused by symptoms (rated as 0=no discomfort, 1=some discomfort, 2=quite a bit of discomfort, and 3=severe discomfort) and effect of symptoms on daily life (rated as 0=no effect, 1=minor effect, 2=significant effect, and 3=very strong effect). Participants could select ‘not applicable’ for symptoms not experienced. Participants could list any ‘other’ symptoms experienced, however no participant reported ‘other’ symptoms.

In addition to Total Number of Symptoms (Number), cumulative scores were calculated by summing scores for the 29 physical symptoms resulting in Total Frequency of Symptoms (Frequency, Cronbach’s $\alpha = .67$), Total Discomfort of Symptoms (Discomfort, $\alpha = .71$), and Total Effect of Symptoms on Life (Effect, $\alpha = .76$) scores. Because these scores correlated highly, a \textit{total symptom composite score} was created by summing Frequency, Discomfort, and Effect (Cronbach’s $\alpha = .89$). The Number score was excluded from calculating the total symptom composite score due to $r = .88$ with Frequency. Additionally, for each type of physical symptom, a symptom composite score was created by summing scores from Frequency, Discomfort and Effect ratings. Cronbach’s alphas ranged between .60 and .96, M=.85, SD=.10, which were considered satisfactory for 3-item scales.

After conducting descriptive analyses, Pearson’s correlations explored the intercorrelations of the physical symptom dimensions (Number, Frequency, Discomfort, and Effect), the total symptom composite score, and well-being measures (depressive symptoms and self-esteem). A square root transformation was applied to the Beck Depressive Inventory when conducting correlations to adjust for skewness. Next, to determine whether assessing effect and discomfort of symptoms contributed unique variance over and above frequency of symptoms in predicting BDI a multiple regression analysis was conducted in which total frequency of symptoms was entered in Step 1 and then total discomfort was entered in Step 2. The regression was repeated with Effect entered at Step 2. These
two regressions were also conducted with self esteem as the criterion variable. All assumptions of regression analysis were met for these analyses although multicollinearity could be considered threatened according to some criteria (e.g., rs of .66 and .75; lowest tolerance was .44); however, the analyses were retained because it was the most direct way to answer our research question (note that the findings should be interpreted cautiously due to multicollinearity tending to lead to underestimates of variance explained or unreliability). Further regressions were then performed to identify the specific individual symptom predictors of depressive symptoms and self-esteem. To reduce risk of Type I errors, alpha level was set at .01 for correlations, partial correlations, and $F$ change at each step of hierarchical regressions (with individual beta weights set at .05 for equations in which $F_{Δ} P<.01$).

RESULTS
A total of 282 questionnaires were sent out. Of those who initially responded to the advertisements, 67 (23.8%) did not return questionnaires, leaving a final sample of 215 participants with a mean age of 31.73 years (SD=4.54). Table 1 shows demographic details of participants. Women were between 15 and 25 weeks gestation (M=18.55, SD=1.28) at the time of participation.

Table 2 shows the percentages of women from the total sample experiencing each symptom, and percentages for Frequency, Discomfort and Effect ratings for the sub-sample of women who reported experiencing each symptom. On average women reported a mean=13.75 symptoms (SD=3.93; range 4-27). The most commonly experienced symptoms were: fatigue (94.9%), increased urination (88.3%), nausea (85.6%), tender breasts (81.4%), headache (76.3%), vaginal discharge (75.8%), flatulence (74.8%), constipation (67%), appetite increase (66.8%), insomnia (64.2%), shortness of breath (61.4%), backache (61.4%), and heartburn (53.0%). Braxton Hicks, Carpel-tunnel and fainting were experienced least with less than 10% of women reporting each.

For the most part symptoms were relatively independent with rs ranging from -.26 to .47 for the frequency of symptoms, and rs ranging -.13 to .74 for the symptoms scores combining frequency, discomfort and effect ratings. The only symptoms with a relatively high r were nausea and vomiting
which correlated .47 (for frequency) and .74 (for combined score). For this reason the two symptoms were collapsed for later regression analyses examining individual symptoms.

For women who experienced symptoms, Frequency totalled for all symptoms correlated highly with both the total Discomfort (r = .76, P<.01) and total Effect (r=.68, P<.01) scores. The most commonly reported symptoms, however, were not necessarily associated with the most Discomfort/Effect on life ratings. Symptoms ranked with severe and/or ‘quite a bit’ of discomfort included fainting, vomiting, headache, backache, carpel tunnel, varicose veins, nausea, fatigue and groin pain (Table 2 displays percentages). The strongest effect on life was perceived to be caused by vomiting, fainting, fatigue, nausea, headache, and insomnia; in addition, about a third of women reporting the symptom(s) described varicose veins, carpel tunnel, backache and increased urination as causing significant effect on their lives.

The total symptom composite score correlated moderately with the Beck Depression Inventory (r = .36, P<.001). In order to establish whether Discomfort of symptoms and Effect of symptoms predicted depressive symptoms over and above Frequency, hierarchical regressions were performed. In Step 1 Frequency accounted for 7.7% of the variance in predicting depressive symptoms, (P<.001). In a second step Discomfort accounted for an additional 4.5% of the variation in depressive symptom scores (P=.001), indicating that women who experienced the most frequent and uncomfortable physical symptoms were most likely to report higher depressive symptoms (the frequency and discomfort scores together explained 12.2% of the variability in the sample’s depressive symptom scores). Similarly, when effect was entered in step 2 instead of discomfort, effect accounted for an additional 6.3% variance in depressive symptoms (P < .001) over and above frequency; therefore, when physical symptoms occurred frequently and also affected the woman’s life, there was a greater chance of the woman reporting higher depressive symptoms (the frequency and effect on life scores together explained 14% of the variability in the sample’s depressive symptom scores).

Symptom composite scores for all 28 symptoms, including the combined nausea-vomiting score were then entered simultaneously into a multiple regression predicting depressive symptoms. The regression was significant (P<.001) and explained 25% of the variance, with fatigue (P<.01) and flatulence (P<.05) significantly predicting depressive symptoms independently. To investigate the possible confounding effects of Beck Depression Inventory items assessing ‘tiredness’ and ‘appetite decrease’, the Beck Depression Inventory minus those items was correlated with the total symptoms composite score; however, the resulting r = .30 (p < .01) was not significantly different from the correlation of the complete Beck Depression Inventory with the symptom composite score. Beck Depression Inventory scores correlated P≤ .01 with each of Frequency, Discomfort and Effect for
fatigue (rs range .21 to .30) and Effect of flatulence (r=.30; Discomfort of flatulence approached significance at r=.16, P<.05).

Next stepwise regressions were conducted to predict self esteem, examining whether Discomfort or Effect predicted added variance over and above Frequency. However, neither Frequency (P <.05) nor Discomfort (P >.05) or Effect (P = .052) significantly predicted self-esteem in these regressions. When the symptom composite scores for the 28 symptoms plus a combined score for nausea-vomiting were entered simultaneously into regressions predicting self esteem resulting they explained 20.9% of the variance (P=.008), with flatulence (P<.01), fatigue (P<.01), tender breasts (P<.05), and congestion (P<.05) predicting self esteem. Examining these four symptoms using the separate symptom indices, only Effect of flatulence (r =-.20, P=.004), and Discomfort and Effect of fatigue (r= -.22 and -.23 respectively, P=.001) correlated significantly with self esteem.

**DISCUSSION**

This study’s first aim was to describe the physical symptoms experienced by women at 15-25 weeks gestation. On the whole, while some symptoms were reported by a large proportion of women, others were less frequently reported. Fatigue was the most frequently experienced symptom (around 95%), followed by increased urination and nausea. Braxton Hicks and carpel tunnel syndrome (which occur mostly during 3rd trimester) and fainting (common in first trimester) were the least frequent.

Both fatigue (reported by 95% of the sample) and nausea (86% of the sample) have been previously investigated. Reports of these symptoms in the current sample suggest a frequency equal to or higher than previously reported although gestational ages vary from study to study. In one previous study, 73% and 50% of women reported experiencing fatigue during first and second trimester respectively, with 46% and 22% reporting nausea in those trimesters. In another study of women in early pregnancy (M=59 days gestation), 96% reported fatigue and 73% reported nausea. Increased urination had not been previously examined on its own; it was reported by over half the participants as occurring very often.

For women who experienced symptoms, higher symptom frequency scores were associated with greater discomfort and more effect on life. However several less common and less frequently experienced symptoms were still associated with greater discomfort and more effect-on-life ratings for a substantial proportion of women. Symptoms causing most discomfort included fainting, carpel tunnel syndrome, varicose veins, vomiting, backache, nausea and headache. Symptoms that caused the most effect on women’s lives were the ones causing most discomfort (just listed) plus insomnia, fatigue and increased urination. Some symptoms such as fainting, carpel tunnel syndrome or varicose
veins, which occurred more infrequently in the overall sample, were reported to disrupt the lives and wellbeing of many of the women who experienced them.

These findings highlight the importance of understanding individual/unique experiences of women suffering from pregnancy-related discomforts, which has clinical implications for healthcare practitioners caring for these women. For example, given the proportion of women who found that pregnancy-related symptoms substantially affected their lives, further preparation of pregnant women for coping with these symptoms may be indicated at preconception or annual primary care examination visits.

The results further suggest that measuring frequency alone may be insufficient in assessing women’s experience of symptoms and that assessing perceived discomfort and effect on life of symptoms enhances our understanding of how physical symptoms affect pregnant women in their daily lives. Previous studies have described physical symptoms only in terms of number or frequency.4,15 This study aimed to examine the relationship between symptoms and psychological wellbeing, primarily depressive symptoms and secondarily self-esteem, and investigated whether additional measurements of severity of discomfort and effect of symptoms on life added to the predictive power over frequency of symptoms alone. Correlation analyses indicated that higher frequency, greater discomfort and more effect on life of symptoms (as a combined score across all symptoms) were related to higher scores for depression and to a lesser extent lower self-esteem scores. These results are consistent with previous findings.4,15 Furthermore, both discomfort and especially the effect-on-life indices contributed over and above frequency alone in predicting depressive symptoms, although this was not found with self-esteem. These findings support the state-dependent theory of depression32; physical symptoms appear to be indicators of, and possibly risk factors for (together with other variables in vulnerable women), depression and low self esteem. Another explanation of the relationship, however, is that depressive symptoms or associated negative cognitions intensify the experience of negative physical symptoms. These findings also provide new evidence about the relationship between pregnancy-related physical symptoms and low self-esteem, not previously investigated.

With regard to individual symptom predictors, the more likely the women were to have a set of two identified symptoms and experience them intensely (fatigue, and flatulence), the higher scores on the depression index they were likely to have. These findings suggest that women reporting these physical symptoms should be screened for depression. A somewhat different set of four symptoms predicted low self-esteem, including flatulence, fatigue, tender breasts and congestion, which might be likely to produce esteem-related effects. The identification of specific symptoms that were
associated with depressive symptoms or low self-esteem advances previous research in contributing to a risk factor model for depression and low self-esteem during pregnancy.

Several study limitations should be noted. First, being a cross-sectional study, conclusions are limited to the gestational period examined and causal conclusions cannot be made since pre-pregnancy variables were not controlled for. As stated above, it is possible that a bi-directional relationship exists between physical symptoms and depressive symptoms/low self esteem. Future research should adopt prospective longitudinal designs and consider other factors related to body experiences during pregnancy (including assessing symptoms that pre-dated pregnancy). Other study limitations include the fact that most participants were older, married, well-educated, in professional or para-professional occupations, and self-reported their data retrospectively and in summary form over a period of weeks (instead of daily diaries). In relation to the occupation of women it is possible that the distress caused by pregnancy symptoms is moderated by the type of work women are engaged in during the day and night. In addition, as in most volunteer-based research, it is possible that women who self-selected to participate in the study were different from the general population. Replication with a larger percentage of women from low socioeconomic groups, different occupational backgrounds, and other methods that do not rely solely on self-selection and self-reports (such as direct observation and partner/obstetrician reports) is needed.

CONCLUSION
There are several clinical implications of this study. Firstly, we have described the physical symptoms occurring during the second trimester of pregnancy in much more detail than before. The subgroup of women who suffer from symptoms were examined to identify aspects of their experience of physical symptoms that were most troublesome and have most clinical relevance. Secondly, given the inter-relationships between pregnancy-related physical symptoms and depressive symptoms (and, to a lesser extent, low self-esteem), when women report any of this constellation of factors, further screening of the other related factors is indicated. Thirdly, we have identified specific physical symptoms which may be particularly important as potential indicators for depressive symptoms and low-self esteem. Finally, assessing the severity of discomfort and perceived effect of symptoms on life, in addition to symptom frequency, may assist clinicians to better understand women’s experiences of symptoms, and more thoroughly assess for risk of depression and low self-esteem.
References


30. American Pregnancy Association: Common discomforts. Available from:


<table>
<thead>
<tr>
<th>Variable</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>16-20</td>
<td>3(1.4)</td>
</tr>
<tr>
<td>21-30</td>
<td>74(34.4)</td>
</tr>
<tr>
<td>31-45</td>
<td>138(64.2)</td>
</tr>
<tr>
<td><strong>Gestation</strong></td>
<td></td>
</tr>
<tr>
<td>15-18.5 weeks</td>
<td>132(61.4)</td>
</tr>
<tr>
<td>19-21 weeks</td>
<td>76(35.4)</td>
</tr>
<tr>
<td>22-25 weeks</td>
<td>7(3.3)</td>
</tr>
<tr>
<td><strong>Parity</strong></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>91(42.3)</td>
</tr>
<tr>
<td>1+</td>
<td>113(52.6)</td>
</tr>
<tr>
<td>Prior miscarriage</td>
<td>11(5.1)</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
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<tr>
<td>Married or de-facto (living together)</td>
<td>201(93.5)</td>
</tr>
<tr>
<td>Single/never married</td>
<td>10(4.7)</td>
</tr>
<tr>
<td>Separated/divorced</td>
<td>4(1.9)</td>
</tr>
<tr>
<td><strong>Highest education</strong></td>
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</tr>
<tr>
<td>Primary education</td>
<td>2(0.9)</td>
</tr>
<tr>
<td>Some and completed secondary education</td>
<td>54(25.2)</td>
</tr>
<tr>
<td>Tertiary education</td>
<td>159(74)</td>
</tr>
<tr>
<td><strong>Employment</strong></td>
<td></td>
</tr>
<tr>
<td>Unemployed/Home carer/Student/Unskilled worker</td>
<td>51(23.7)</td>
</tr>
<tr>
<td>Para-professional (incl. clerical/retail) or Professional</td>
<td>74(34.4)</td>
</tr>
<tr>
<td>Professional</td>
<td>85(39.5)</td>
</tr>
<tr>
<td>Other</td>
<td>5(2.3)</td>
</tr>
<tr>
<td><strong>Annual family income</strong></td>
<td></td>
</tr>
<tr>
<td>&lt;A$44, 000 (about US$36, 750)</td>
<td>34(15.8)</td>
</tr>
<tr>
<td>A$75-104, 000</td>
<td>62(28.8)</td>
</tr>
<tr>
<td>&gt;A$105, 000 (about US 87, 630)</td>
<td>58(27)</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
</tr>
<tr>
<td>Australian</td>
<td>176(81.9)</td>
</tr>
<tr>
<td>UK or Europe</td>
<td>16(7.4)</td>
</tr>
<tr>
<td>Other</td>
<td>16(7.4)</td>
</tr>
</tbody>
</table>
Table 2
Number and Percent (%) of women experiencing each symptom in the previous 8 weeks, and the Frequency, Discomfort and Effect on Life Ratings (in %) for Women Who Experienced Each Symptom.

<table>
<thead>
<tr>
<th>Symptom</th>
<th>N and Percent (%) experiencing symptom</th>
<th>Frequency (%) in women experiencing symptom</th>
<th>Severity of Discomfort (%) in women experiencing symptom</th>
<th>Effect on Life (%) in women experiencing symptom</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Rarely Sometimes Very Often None/ Minor Quite a bit Severe None/ Minor Significant Very Strong</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fatigue</td>
<td>204 (94.9)</td>
<td>9.3 44.1 46.6</td>
<td>60.8 33.8 5.4</td>
<td>43.1 39.7 17.2</td>
</tr>
<tr>
<td>Incr. urination</td>
<td>189 (88.3)</td>
<td>6.3 35.4 58.2</td>
<td>79.9 16.4 3.7</td>
<td>67.2 23.8 9</td>
</tr>
<tr>
<td>Nausea</td>
<td>184 (85.6)</td>
<td>28.8 28.8 42.4</td>
<td>48.4 41.3 10.3</td>
<td>61.4 21.7 16.8</td>
</tr>
<tr>
<td>Tender breasts</td>
<td>175 (81.4)</td>
<td>19.4 41.1 39.4</td>
<td>58.9 31.4 9.7</td>
<td>84.6 10.3 5.1</td>
</tr>
<tr>
<td>Headache</td>
<td>164 (76.3)</td>
<td>36 43.3 20.7</td>
<td>47 33.5 19.5</td>
<td>61.6 23.2 15.2</td>
</tr>
<tr>
<td>Vaginal discharge</td>
<td>163 (75.8)</td>
<td>20.2 39.3 40.5</td>
<td>90.8 6.8 2.4</td>
<td>92 6.1 1.8</td>
</tr>
<tr>
<td>Flatulence</td>
<td>160 (74.8)</td>
<td>21.2 52.5 26.3</td>
<td>83.1 14.4 2.5</td>
<td>91.2 6.9 1.9</td>
</tr>
<tr>
<td>Constipation</td>
<td>144 (67)</td>
<td>36.1 41.7 22.2</td>
<td>61.1 31.2 7.6</td>
<td>82.6 14.6 2.8</td>
</tr>
<tr>
<td>Appetite increase</td>
<td>143 (66.8)</td>
<td>11.2 53.8 35</td>
<td>44.8 4.2 0.7</td>
<td>88.8 7.7 3.5</td>
</tr>
<tr>
<td>Insomnia</td>
<td>138 (64.2)</td>
<td>26.1 44.9 29</td>
<td>61.6 32.6 5.8</td>
<td>53.6 32.6 13.8</td>
</tr>
<tr>
<td>Short of breath</td>
<td>132 (61.4)</td>
<td>34.8 52.3 12.9</td>
<td>87.1 11.4 1.5</td>
<td>85.6 12.1 2.3</td>
</tr>
<tr>
<td>Backache</td>
<td>132 (61.4)</td>
<td>25 42.7 33.3</td>
<td>43.2 40.9 15.9</td>
<td>64.4 25 10.6</td>
</tr>
<tr>
<td>Heartburn</td>
<td>114 (53)</td>
<td>39.5 39.5 21</td>
<td>64.9 29.8 5.3</td>
<td>86.8 10.5 2.6</td>
</tr>
<tr>
<td>Dizziness</td>
<td>104 (48.4)</td>
<td>63.5 26 10.6</td>
<td>83.6 12.5 3.8</td>
<td>83.6 10.6 5.8</td>
</tr>
<tr>
<td>Congestion</td>
<td>101 (47)</td>
<td>27.7 39.6 32.7</td>
<td>72.3 18.8 8.9</td>
<td>73.1 21.8 5</td>
</tr>
<tr>
<td>Vomiting</td>
<td>95 (44.2)</td>
<td>40 36.8 23.2</td>
<td>40 35.8 24.2</td>
<td>54.7 20 25.3</td>
</tr>
<tr>
<td>Bleeding gums</td>
<td>95 (44.2)</td>
<td>47.4 33.7 18.9</td>
<td>95.8 3.1 1.1</td>
<td>95.8 3.1 1.1</td>
</tr>
<tr>
<td>Pelvic pressure</td>
<td>75 (34.9)</td>
<td>30.7 44 25.3</td>
<td>68 25.3 6.7</td>
<td>82.7 10.7 6.7</td>
</tr>
<tr>
<td>Leg Cramps</td>
<td>73 (34)</td>
<td>57.5 34.2 8.2</td>
<td>61.6 32.9 5.5</td>
<td>89 8.2 2.7</td>
</tr>
<tr>
<td>Appetite decrease</td>
<td>62 (28.8)</td>
<td>33.9 43.5 22.6</td>
<td>88.7 6.5 4.8</td>
<td>88.7 8.1 8.1</td>
</tr>
<tr>
<td>Groin pain</td>
<td>60 (28)</td>
<td>28.3 55 16.7</td>
<td>63.3 33.3 3.33</td>
<td>83.3 13.3 3.3</td>
</tr>
<tr>
<td>Nose bleeds</td>
<td>60 (27.9)</td>
<td>56.7 33.3 10</td>
<td>98.3 1.7 0</td>
<td>93.3 5 1.7</td>
</tr>
<tr>
<td>Hot flushes</td>
<td>51 (23.7)</td>
<td>54.9 37.3 7.8</td>
<td>84.3 9.8 3.9</td>
<td>94.1 3.9 2</td>
</tr>
<tr>
<td>Swelling</td>
<td>36 (16.7)</td>
<td>50 38.9 11.1</td>
<td>86.1 11.1 2.8</td>
<td>86.1 8.3 5.5</td>
</tr>
<tr>
<td>Haemorrhoids</td>
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<td>42.9 35.7 21.4</td>
<td>71.4 28.6 0</td>
<td>89.3 10.7 0</td>
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<tr>
<td>Varicose Veins</td>
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<td>37 33.3 29.6</td>
<td>66.7 22.2 11.1</td>
<td>66.7 29.6 3.7</td>
</tr>
<tr>
<td>Braxton hicks</td>
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<td>50 30 20</td>
<td>70 25 5</td>
<td>95 5 0</td>
</tr>
<tr>
<td>Carpel tunnel</td>
<td>16 (7.5)</td>
<td>25 37.5 37.5</td>
<td>43.7 43.7 12.5</td>
<td>68.7 25 6.2</td>
</tr>
<tr>
<td>Fainting</td>
<td>12 (5.6)</td>
<td>33.3 50 16.7</td>
<td>41.7 33.3 25</td>
<td>41.7 33.3 25</td>
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</table>