PREGNANCY SICKNESS: HOW MIGHT COUNSELLING HELP?

MICHELLE NICHOLSON PROVIDES SOME PRACTICAL RECOMMENDATIONS FOR COUNSELLING WOMEN SUFFERING FROM HYPEREMESIS GRAVIDARUM

'I feel so embarrassed', explained 'Pam', in her first counselling session. 'My friends all glowed when they were pregnant. But I can't move without feeling sick. I smell awful because I feel too faint to stand or even sit in the shower. I'm so lonely and bored, I've not left the house in weeks. Whatever I eat comes straight back up, it's exhausting. My back and throat are sore because, when I've finished vomiting, I keep on retching. I'm terrified that my baby will die because I'm losing weight instead of putting it on. I can't stop crying, and I'm scared. This isn't how I imagined pregnancy would be!'

A common response to the notion of counselling for women with pregnancy sickness, is: 'But you can't stop them vomiting, so what do you actually do?' This is what I often encounter when I tell other therapists that I set up the UK's first counselling service for women affected by Hyperemesis Gravidarum (HG) in 2016. This article aims to highlight what can be done for these women, by offering a brief outline of my clinical practice with this new client group. It is a call to counsellors working in healthcare settings to envisage how we might enable more women affected by this distressing and debilitating medical condition to access psychotherapeutic support services, where and when they are needed.

Hyperemesis Gravidarum, an extreme form of pregnancy sickness, affects approximately two in every 100 women. It remains a puzzling medical condition, with no known cause or cure and, until the 1940s, it constituted a significant cause of death in pregnancy, due to lack of knowledge about dehydration and electrolyte imbalance.[1] HG is associated with depression, anxiety and psychological distress. Poor mental health is the result of the suffering caused by HG, rather than being causal. It is a severe, chronic illness that reduces quality of life, impairs functioning and negatively affects relationships.[2] 'Expressions of empathy by healthcare professionals are frequently lacking and particularly desired.'[3]

I lived with this medical condition for several months with each of my own pregnancies and have previously written about my research on this topic.[4,5] Reflecting on this study, McLeod suggests it 'functions as an opening for dialogue between therapists, women suffering from HG, and specialist support groups and healthcare workers in the maternity field.'[6] He also states that 'research can function as an effective means of starting a conversation around a topic that has not previously been discussed within the counselling and psychotherapy community.'[6] The present article has been written with a view to initiating such a conversation.

WOMEN'S EXPERIENCE OF HG

Women with HG often describe feeling disconnected from their own bodies and their babies in utero. Commonly house-bound, they feel isolated and unacknowledged. For women who are debilitated by, and experiencing a loss of self in, their illness, the opportunity to engage with counselling can be therapeutic and empowering. It can enable them to reclaim voice and agency, particularly in a context in which their pregnancy may have been medicalised or pathologised by others, thus allowing them to envision new ways forward.

'Tina' presented for counselling nine weeks into her first pregnancy, by which time she had been hospitalised twice to receive intravenous fluids due to her excessive vomiting. She described feeling panicky, anxious, disempowered, completely overwhelmed by her nausea, vulnerable and no longer her usual self. Having been signed off work by her GP, she felt socially isolated, and hurt by her line manager's minimisation of her illness, with comments such as, 'It's only morning sickness – I carried on working when I was pregnant.'

In 'Grace's' first counselling session, she disclosed, 'I just can't go on like this for another day, suffering so much. Even though I tried so hard to conceive, enduring three rounds of IVF, all I can think about is terminating my pregnancy, just so this torture will end.' With counselling support, Grace was able to develop new coping strategies and mindsets, which enabled her to continue with her pregnancy, and give birth to a healthy baby girl. An estimated 10 per cent of women with HG go on to terminate their wanted pregnancies due to the intolerable nature of their symptoms and inadequate healthcare support.[2]

COUNSELLING FOR WOMEN AFFECTED BY HG

Since setting up the counselling practice, I have worked pluralistically with clients who are currently suffering with HG, in recovery post HG, preparing for recurring HG, or grieving a pregnancy ended as a result of HG, as well as partners of women affected by HG.

Counselling is offered to clients by telephone because women who are currently suffering with nausea or vomiting can find it difficult to leave their homes. They sometimes feel uncomfortable around not being able to wash or care for their personal appearance, and they may need to lie down or vomit during a counselling session.

Flexible meeting patterns have been agreed with clients where appropriate. This has included: reducing session length when a client is unable to manage a full 50 minutes on the phone; working with breaks during a session, where this is helpful for clients (particularly around vomiting episodes); rescheduling usual meeting times to accommodate hospital appointments or antenatal classes; meeting requests to reduce or increase session frequency as HG symptoms dissipate or proliferate; and 'leaving my door open' for clients to contact me again post HG or post childbirth.

Having established the absence of 'good practice' guidelines for counselling women impacted by this illness, initially, there was limited clarity on my part about the issues that clients might bring, and the skills and competencies I might draw on in working with them. The only certainty was my own personal knowledge that, when I was struggling to cope with HG myself, I would have benefitted from counselling support. On this basis, my clinical practice has developed out of collaboration with my clients, openly learning from them about their preferences, and what they have found most, or indeed least, helpful.

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Two years on, through analysis of my clinical notes of counselling sessions, I have identified a number of psychotherapeutic 'tasks' and 'methods' specific to this new client group. My hope in sharing this information is that it might enable more counsellors in healthcare settings to proactively offer support to women impacted by HG; to develop 'HG-friendly' policies in their own service provision; to learn more about the mental health impacts of HG (perhaps by visiting the website of national charity Pregnancy Sickness Support); and to consider how they might draw from or adapt aspects of the following approach to suit their own clinical practice.

PSYCHOTHERAPEUTIC TASKS AND METHODS

Developing HG coping strategies
Clients might want to focus on collaboratively developing coping strategies for the following: anxiety; antenatal or postnatal depression; ruminating; debilitating nausea; responding to other people's unhelpful comments about HG (by, for example, visualising an 'HG shield'); sleep difficulties; impacted relationship with food; or impending labour and delivery.

Working with relationships impacted by HG
Clients might work on: enhancing communication skills around their physical and emotional needs; feeling misunderstood or alienated by others; changing relationships with their own parents; identifying difficulties in couple relationships coming to the fore in HG; the dynamic of becoming an ill person and being cared for by relatives; and complex feelings around an inability to care for their other children while so debilitated, or around their children witnessing their HG suffering.

Psycho-education in an HG context
Where appropriate, I offer information and advice to clients. Examples include: referencing evidence-based obstetric guidelines on managing HG[2] (for example, the importance of rest); debunking myths about HG (particularly around the duration of symptoms and the use of ginger); and how to access specialist HG medical care. I also embrace any opportunity to demystify counselling, engaging clients in conversations about what it is, and how we might work together in ways that suit them.

Supporting transition to motherhood
Methods for supporting women in their transition to motherhood while pregnant might include: addressing fears, fantasies and anxieties; planning support networks; identifying existing transferable skills; recognising difficulties around connecting with their baby in utero, in the context of HG suffering; exploring body image issues; acknowledging the significance of their first reference to 'the baby', having connected with the illness rather than the pregnancy until that point; and working with complex or ambivalent feelings around their experience of key pregnancy events (for example, hearing their baby's heartbeat, wearing their first maternity clothes, discovering their baby's gender, or feeling the baby moving).

Creating an HG self-care plan
When required, I have collaborated with clients in developing their own bespoke self-care plan or 'HG survival kit' to draw from when overwhelmed by symptoms. This has included: lists of available resources, personalised self-affirmative statements, key support networks, high-risk triggers, distraction and self-care activities, relaxation exercises, and relevant websites and helplines.

Identifying resources
Clients have found it helpful to acknowledge the loss of previous cultural and social resources, which are no longer accessible during HG pregnancy, such as high-intensity sports, TV or cooking, as movement, lights, sounds and odours can aggravate nausea. They learn to tailor any new resources to the degree of their current functioning and to embrace 'the therapeutic use of everyday practices'.[7] Examples manageable with severe HG have included: stroking a pet, sitting in the garden, completing puzzle books while lying down and – of relevance to most clients – the website of the charitable agency, Pregnancy Sickness Support.

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Expanding support networks
HG tends to leave women bed-bound or house-bound for lengthy periods. Clients have used counselling to explore ways of managing social and emotional isolation. Examples include how they might increase contact with friends and family, identify and expand their support network, increase communication skills around explaining HG debilitation to others, and, access specialist HG healthcare.

Working with loss and grief
Clients commonly use the counselling space to acknowledge and make sense of the loss and grief they experience in their HG illness. This might include loss of self, identity, anticipated pregnancy, functioning, role and control.

For those women who have terminated a pregnancy due to HG, bereavement work might incorporate: validating the unbearable nature of HG symptoms in the context of ending a planned or wanted pregnancy; working towards increasing self-compassion around decision making; use of ritual or ceremony in honouring the baby's existence, where this is desired by the client; and making sense of complex feelings around shame, regret, emptiness, involuntary childlessness or limiting family size.

Monitoring mood and anxiety
While some degree of low mood and worry is to be anticipated and normalised in the context of HG illness, counselling has been a welcome support for several clients in my initial and ongoing assessment of clinical levels of depression, anxiety or suicidal ideation, working with women to access their local mental health midwifery or crisis support services, for additional care where appropriate.

Reframing illness
Key to my counselling approach has been enabling new mindsets, encouraging women to re-story or cognitively reframe their HG suffering. Exploration of themes, life scripts and beliefs inherent in a client's illness narrative creates potential for incorporating positives and new ways forward.

My work with 'Molly', for example, centred around working towards a shift in mindset, from 'I'm scared of HG and I have to fight it; if I sleep during the day, I'm lazy', to focusing her limited energy on accepting her illness, caring for herself while so debilitated and giving herself permission to rest. For 'Clara', the counselling process enabled a gradual cognitive shift from, 'this is not the perfect pregnancy I dreamed of; when will my suffering end?' to valuing her 'good enough' pregnancy and pacing herself with self-compassion, by focusing on one day at a time.

Highlighting clients' progress
A further key dimension has been remaining alert to any positive change in clients, however small. This has included, for example, noticing enhanced identification with pregnancy as opposed to illness, highlighting a shift in focus from HG symptoms to preparing for labour or mothering, and honouring key milestones, events or firsts in the pregnancy journey. For some clients, the rhythm of weekly counselling sessions promotes a sense of pacing, with each one representing 'another week of HG managed or survived'.

Adopting a strengths-based approach
Counselling can provide women with a safe, supported space whereby they can balance the losses inherent in their HG illness with potential gains. New coping strategies, mindsets and life skills developed in the context of HG (for example, asking for help, pacing or patience), can be transferrable to parenting. The HG illness experience presents a valuable opportunity to practise slowing down and self-care in pregnancy, increase self-awareness around high-risk triggers to anxiety or low mood, address relationship issues evident in HG before adjusting to parenting, and, experiment with prioritising one's own and the baby's needs and wellbeing, as opposed to pleasing others. There is also the potential for women who have survived HG to be left with an enhanced sense of achievement, courage and personal resilience. For some women, learning techniques to ride out HG nausea has proved useful preparation for labour contractions.

Learning from my clients about what is most helpful in counselling sessions continues to inform my ongoing practice. Promoting clients' agency in their management of HG symptoms, and their use of counselling, enables them to redress the sense of disempowerment inherent in the HG experience. Adopting a strengths-based approach encourages clients to re-story their illness narrative, acknowledging gains and new resources, as well as losses. Engaging with supervision ensures that my own personal experiences of HG remain distinct from those shared by my clients. Drawing on multiple sources of knowledge around HG, therapy and distress allows each client to be offered a tailored approach to care, encompassing as full an understanding of her suffering as possible.

A NEW COUNSELLING CONVERSATION

As a counsellor, I feel privileged to be empathically witnessing so many women's 'heroic stories'[7] of surviving Hyperemesis Gravidarum. My hope is that the healthcare counselling sector might begin to more widely support these women, too. Let's reflect on how we might improve access to a range of psychotherapeutic services for women debilitated by HG. Or how we might routinely screen for clinical levels of mental health distress in women struggling to cope with this medical condition. Once an HG diagnosis has been established by a GP or hospital medic, even a single or small number of counselling sessions could potentially alleviate despair, acknowledge suffering and increase personal resilience, thus enabling women to be better professionally cared for. Such a conversation is ethically required and long overdue.

HG PRESENTING ISSUES

ANXIETY & DEPRESSION	Debilitation, distress, isolation, panic, suicidal ideation, inconsistency
SELF-CARE DIFFICULTIES	Loss of functioning, struggle to allow self to rest or value own needs
INABILITY TO WORK	Loss of role, workplace relationships, financial stress, phased return
HOSPITALISATIONS	Interactions with healthcare professionals, medication use, loss of agency
ANTICIPATED PREGNANCY	Disappointment, sense of unfairness, lack of joy and engagement
SELF AND IDENTITY	Ill not pregnant, weak, loss of self, adverse comparison, different
RELATIONSHIP WITH FOOD	Fear of food or vomiting, weight loss or gain, guilt, pressure, body image
MATERNAL DISCONNECTION	Inability to care for other children, difficulties bonding with foetus
ILLNESS NARRATIVES	Themes, beliefs, life scripts, self-image, acceptance, accessing care
OTHERS' RESPONSES	Discounted, medicalised, judged, disbelieved, misunderstood
PRE-MOTHERHOOD	Reduced confidence, concerns, identity, key pregnancy events
PREGNANCY TERMINATION	Guilt, shame, loss, grief, regret, judged, minimised, pressured

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All case examples are composites to protect client confidentiality.

GOALS AND FOCUS OF HG COUNSELLING

Cope with nausea, vomiting, other HG symptoms	Communicate distress and overwhelm	Reclaim agency	Increase self-care while debilitated	Connect with pregnancy
Manage anxiety, panic, mood, depression	Reduce isolation	Increase resilience and confidence	Manage suicidal ideation	Explore impact on self, identity, body image
Prepare for labour, mothering, further HG pregnancy	Increase support network	Acknowledge loss in illness	Manage pregnancy termination ideation	Recuperate from HG
Manage others' responses to HG	Manage impact on relationships	Manage relationship with food	Grieve HG pregnancy termination	Process previous HG trauma

READER RESPONSE
The author would welcome feedback on this article. To contact her, please email michelle@hyperemesiscounselling.co.uk