Michelle Nicholson talks to Sally Brown about her pioneering counselling service supporting women with extreme pregnancy sickness

Ten years after Michelle Nicholson suffered excessive nausea and vomiting with two pregnancies, she was still struggling to come to terms with the lack of concern for her emotional wellbeing. 'While the healthcare professionals with whom I came into contact did a wonderful job of providing the necessary physical care, it niggled at me that I was not offered any psychological support,' she says. Eventually, that niggle drove her to carrying out postgraduate research into the value of counselling for sufferers of hyperemesis gravidarum (HG), or extreme pregnancy sickness, and to set up the UK's first HG-aware counselling service.

A separate condition from the 'morning sickness' common in the first trimester, HG can continue throughout pregnancy, leaving sufferers bed- or housebound, hospitalised for dehydration and electrolyte imbalance, and suffering weight loss and muscle wastage. Affecting around two per cent of pregnancies in the UK – approximately 20,000 women a year – it has no known cause or cure and, until the introduction of IV fluids in the 1940s, was a significant cause of death in pregnancy.

'Approximately 10% of HG sufferers are driven to terminate a wanted pregnancy, citing as contributory factors inability to care for self and family, fear that they or their baby could die, and unhelpful attitudes of healthcare providers,' says Nicholson. 'The Royal College of Obstetricians and Gynaecologists[1] released guidelines in 2016 recommending that counselling or psychological support be offered to women affected by HG, where required. And yet, according to the national charity Pregnancy Sickness Support, women's mental healthcare needs remain under-supported by practitioners, both during and following HG pregnancies.'

A former social worker, when Nicholson was studying for her MSc in counselling studies at the University of Edinburgh, she focused her research study on the therapeutic value of emotional expression around HG. Witnessing her research participants' accounts of inadequate mental health support and minimised or discounted suffering, Nicholson says she felt ethically compelled to set up the UK's first HG counselling service in 2016. Now a BACP senior accredited counsellor, she works one day a week as a sole practitioner alongside her main role at the University of Edinburgh student counselling service.

Working one day a week limits her caseload capacity to five women at a time, for whom she offers telephone counselling on a short- or longer-term basis, depending on the level of support required. 'Most find me through Pregnancy Sickness Support,' she says. 'I don't actively advertise my service because I don't want to be in the position of turning women away when there is nowhere to refer them to.'

'Sometimes we just have to do what's needed'

She is keen to encourage other counsellors to become more HG-aware so they can offer effective support. 'It is not unusual for women affected by HG to encounter people who are dismissive, unsympathetic or disbelieving,' she says. 'So where a counsellor builds trust and demonstrates empathy, it can be particularly restorative for this neglected client group.'

The emotional impact of HG is complex. 'Women often feel embarrassed,' says Nicholson. 'It can be very isolating emotionally. They feel like they are already failing as a mother, that other women can cope so why can't they? Many women experience ante- or postnatal depression or anxiety as a result of their HG suffering. An estimated 18% go on to fulfil the full criteria for PTSD diagnosis. Sometimes, a previous experience of HG may not be a client's presenting issue, but it will have had an impact on them and there needs to be an awareness of it.'

Working with an HG client might involve developing coping strategies using a strengths-based approach; working with relationships impacted by HG; supporting transition to motherhood or destabilised maternal-role identity; expanding support networks to reduce isolation; working with loss and disruption; bereavement support around pregnancy termination due to severity of HG symptoms; and managing mood, anxiety and panic, or processing previous HG trauma. There may also be work around fear of further pregnancy or complex grief around involuntary childlessness or limited family size due to HG. 'The opportunity to engage with counselling can enable women to reclaim voice and agency, particularly in a context in which their pregnancy may have been medicalised or pathologised by others, allowing them to envision new ways forward,' says Nicholson.

Her mission to raise awareness has recently involved consulting on a new documentary, *Sick: The Battle Against HG*,[2] and speaking at medical conferences such as the International Colloquium on Hyperemesis Gravidarum. 'I'm usually the only counsellor in a room full of medics,' she says. 'But my papers have stimulated a lively discussion on the urgent need to improve and widen access to counselling for women, partners and families affected by HG, both during and following pregnancy, and the need for CPD resources to enable counsellors to incorporate HG knowledge into their general clinical practice.' ■

■ **www.hyperemesiscounselling.co.uk**

REFERENCES

1. Shehmar M *et al*. The management of nausea and vomiting of pregnancy and hyperemesis gravidarum. Green-top guideline No 69. London: Royal College of Obstetricians and Gynaecologists; 2016. **2.** Available on Vimeo and Amazon Prime. **www.facebook.com/thesickfilmHG/videos/883966668785885**