



The effect of counselling on nausea and vomiting in pregnancy in Turkey



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ABSTRACT

Objectives: The aim of this study was to assess the effects of follow-up counselling on the duration and severity of nausea and vomiting in pregnant women.

Study design: This study is quasi-experimental and included 62 pregnant women with nausea and vomiting. The group that received counselling was considered to be the experimental group, and the group that received a standard outpatient clinic service was the control group. Data were collected with a demographic data form, that is, the Nausea and Vomiting in Pregnancy Instrument and Pregnancy Unique Quantification of Emesis and Nausea. Significance tests of the differences between two mean values, the Mann–Whitney U test and survival analyses were used to test the hypotheses.

Results: In pregnant women with mild or moderate nausea and vomiting, nausea and vomiting terminated in a significantly shorter time in the experimental group than in the control group ($p < 0.001$), but this difference was not significant for pregnant women with severe nausea and vomiting ($p > 0.05$). In addition, the number of weekly telephone follow-ups in the experimental group was significantly smaller ($p < 0.001$).

Conclusion: Counselling effectively reduced the duration and severity of mild or moderate nausea and vomiting during pregnancy. However, it did not affect the duration of severe nausea and vomiting during pregnancy.

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Introduction

Nausea and vomiting in pregnancy (NVP) can emerge soon after pregnancy is diagnosed and is often the first sign of pregnancy. The global rates of NVP were reported to range from 35% to 91%, and the meta-analytic average rate was 69.4% [1]. Specifically, this rate ranged from 60.6% to 72.9% in the Turkish population [2–4]. The severity of symptoms may range from mild nausea to unrelenting nausea with or without retching and/or vomiting, which can occur during the day or at night and often lasts throughout the day [5]. Hyperemesis gravidarum (HG) affects 0.5–2% of pregnancies and is characterized by persistent vomiting, dehydration, and weight loss, often requiring hospitalization for treatment [6]. Women with NVP often try to manage their symptoms using their own coping methods, and most women require support to manage these symptoms. Because the aetiology of NVP is not yet fully known, its treatment approaches do not generally focus on its causes, but rather focus

on alleviating or eliminating its symptoms. However, different stimuli may affect the severity and duration of NVP. Thus, the factors that increase or decrease NVP need to be determined, and individualized interventions should be initiated to strengthen coping mechanisms for NVP. Currently, medical approaches are usually used to alleviate or eliminate NVP. However, sufficient evidence indicating that medical approaches are effective is not currently available [7,8].

Counselling based on individual characteristics using holistic nursing care and including evidence-based nursing practices can effectively treat NVP. As a result, the stimuli that trigger symptoms need to be determined. Furthermore, scientific, data-based nursing approaches should be applied, and their effectiveness should be evaluated [9].

Background

The aim of this study was to evaluate the effects of counselling involving nursing interventions directed towards alleviating NVP. Clinical observations have revealed differences in the effects of various stimuli on women with NVP. Therefore, individualistic counselling, rather than counselling with a structured content, may be

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more effective. Roy's adaptation model (RAM) was used to provide systematic nursing care and create nursing-specific knowledge because it was suitable for the aim of the study and the nursing intervention performed. This model focuses on the individual's behaviour and stimuli of their behaviour and enables them to adapt to changes [10]. In this study, the stimuli and behaviours of pregnant women with NV were determined using RAM, counselling was given, and the effects of the counselling on NVP were examined.

Roy's adaptation model (RAM)

RAM has been considered one of the most highly developed and widely used conceptual descriptions of nursing. Model development began in the late 1960s, and since then, nurses in the United States and around the world have helped Roy to clarify, refine, and extend the concepts. Roy was influenced by studies in liberal arts and the natural and social sciences, and he focused on contemporary movements in nursing knowledge and the continued integration of spirituality with an understanding of the role of nursing in promoting adaptation [10].

RAM defines human beings as an adaptive system that interacts with internal and external environments. According to Roy, a human being is more than the sum of its parts and shows diversity [10]. Thus, recognizing individuality is very important in nursing care. Stimuli play an important role in human behaviours. A stimulus has been defined as something that provokes a response, and it is the point of interaction of the human system with the environment. Stimuli may originate from either the external environment or the internal environment of individuals. Environmental stimuli may threaten individuals or increase the development of individuals for adaptation [10,11]. Roy categorized these stimuli as focal, contextual and residual. Adaptation is realized when individuals show positive reactions to stimuli. Behaviours that are the results of responses to stimuli are consequently categorized as "adaptive" or "non-adaptive". Roy evaluates human behaviours in four modes: physiological, self-concept, role function, and interdependence. The physiologic mode includes the physical and chemical activities of individuals. The self-concept mode includes the beliefs, feelings and self-perception of individuals as well as the perceptions of others towards them based on the spiritual and psychological integrity of individuals. The role-function mode focuses on individuals' life roles. The interdependence mode includes the interaction of individuals with others as part of love, respect and values. Each mode interacts with others, and a change in one affects the rest [10].

Nausea and vomiting in pregnancy (NVP)

NVP starts between the 4th and the 9th weeks of gestation and peaks between the 7th and the 12th weeks of gestation [12]. In a study by Einarson et al., 32.7% of pregnant women experienced nausea without vomiting, and 23.5% of pregnant women experienced NVP continuing into the third trimester. In addition, NVP was rated as mild in 40%, moderate in 46% and severe in 14% of the cases. In a study of a Turkish population, NVP was found to be mild in 42% of the women and moderate or severe in 18.6% of the women [2]. Hyperemesis gravidarum, the most severe form, was shown to affect 0.5–2% of women in another study [1].

Although the aetiology of NVP is not yet known, some biopsychosocial factors are thought to produce or increase symptoms. Changes in the hormones oestrogen, progesterone, and especially human chorionic gonadotropin (hCG) during pregnancy have been proposed to cause NVP [13,14]. In addition, the physiological factors causing NVP include genetic, allergic and vestibular conditions [14,15]. The psychosocial factors leading to NVP

include unplanned pregnancy, perceived stress, psychosocial maladaptiveness and a lack of social support [14,16–18]. A study of a Turkish population showed a relationship between NVP and experiencing nausea and vomiting in the previous pregnancy, a low acceptance of pregnancy, a low adaptation to marriage, tiredness, anxiety and depression but no significant relationship between NVP and perceived social support [2–4,19–21].

NVP negatively affects the quality of life of pregnant women. In one study, women with NVP reported that their daily life activities changed and that they spent most of their time focusing on NVP, felt tired due to NVP and always felt the need to rest [22]. NVP also adversely affects pregnant women's psychology. These women generally suffer from physical, social and emotional isolation due to a loss of control, a need for help, and guilt [22–25]. Women with NVP have decreased self-confidence, and their communication with their spouses and friends is affected. They experience a loss of control, anxiety and fear of being sick in public, mostly because they believe that they may vomit in front of other people and because they fail to fulfil their roles at home and work [22,23,26].

At present, treatments often focus on the symptoms of NVP. Pregnant women may have concerns about pharmacological interventions due to a lack of knowledge about the side effects of medication and their effects on the health of the foetus [8]. Therefore, many women with NVP may prefer to decrease their symptoms by using personal coping strategies or non-pharmacologic methods recommended by health professionals, such as changes in their diet or lifestyle [27–29]. Many of the non-pharmacological methods directed towards the treatment of NVP are nursing interventions.

The aim of this study was to assess the effects of follow-up counselling on the duration and severity of nausea and vomiting in pregnant women.

The following hypotheses were tested.

H1. The severity of nausea and vomiting in pregnant women in the experimental group is lower than that in the control group.

H2. Nausea and vomiting in pregnant women terminated sooner (earlier gestational week) in the experimental group than in the control group.

H2a. *Mild nausea and vomiting in pregnant women terminated sooner (earlier gestational week) in the experimental group than in the control group.*

H2b. *Moderate nausea and vomiting in pregnant women terminated sooner (earlier gestational week) in the experimental group than in the control group.*

H2c. *Severe nausea and vomiting in pregnant women terminated sooner (earlier gestational week) in the experimental group than in the control group.*

Methods

Study design

This study is comparative and quasi-experimental and was conducted at the obstetrics clinic of Dokuz Eylül University Hospital in Turkey between 17 July 2008 and 25 February 2010 (control group: July 2008–May 2009; experimental group: August 2009–February 2010).

Maternity care is provided at family health centres and hospitals in Turkey. Midwives, nurses and general practitioners at family health centres provide routine antenatal care and counselling free of charge. If women require non-routine appointments or referrals, they are observed by obstetricians at government or university hospitals. At the study hospital, physicians conduct pregnancy

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