CRITICAL ISSUES IN THE CARE OF PREGNANT WOMEN WITH EATING DISORDERS AND THE IMPACT ON THEIR CHILDREN

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ABSTRACT

Pregnancy and eating disorders is a subject that has received relatively little attention in the literature. Nevertheless, serious complications have been found in both the mother and the baby during both pregnancy and post partum period. This article alerts practitioners to the physical and psychological risks that imperil pregnant women with histories of recent eating disorders, describes the experiences of three women with eating disorders during pregnancy whose children developed eating difficulties, and suggests some guidelines for the screening and care of women with eating disorders and their babies. J Midwifery Womens Health 2000;45:299–305 © 2000 by the American College of Nurse-Midwives.

INTRODUCTION

Statistics show that 5–10% of America's population experiences anorexia nervosa or bulimia (1). Unfortunately, 90% of these individuals are women who are of childbearing age (1–3). The annual mortality rate associated with anorexia nervosa is 5.9%, and this is 12 times higher than the annual death rate due to all causes of death in females ages 15–24 (4). Although mortality rates for bulimia nervosa are lower, multiple medical complications from the disorder are possible and death can occur (5).

The presence of an eating disorder (ED) during pregnancy can have far-reaching adverse effects on the mother and fetus during all stages of the pregnancy (6, 7). Nursing research is replete with studies addressing pregnancy, but little of it addresses issues of pregnancy and eating disorders. Given recent reports that anorexic and bulimic symptoms are significantly higher in women of childbearing age (7), there is a real need to familiarize practitioners with the issues of detection, assessment, and intervention.

In an effort to alert practitioners to the physical and psychological issues that confront pregnant women with eating disorders, this article reviews the research, provides vignettes from three case studies, and suggests guidelines for the care of pregnant women with eating disorders and their babies. Case report narratives can provide an "inner view of the person" (8); by treating people as the expert witnesses in the matter of their own lives, their stories can provide a point of entry into life's experiences as perceived by them. Case narratives also help to counteract the problem of reducing people to numbers in the search for abstraction and generalization (9–11).

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THE INTERVIEWS

The three women whose stories are summarized were in treatment at a local center for eating disorders and had come to the attention of one of the authors because of difficulties with their babies. Case details were altered slightly to preserve privacy. All three women had mixed anorexic–bulimic symptoms. There were several other women who might have been referred for interviews at the center but were not considered far enough along in their recovery. The women had sought treatment after their first pregnancies when eating disorder symptoms increased. Given the rarity of this phenomenon, the author invited these three women to interview with a focus on their experiences with their young children. They were all far along in their own recovery but still struggling with their young children. All of them had been sexually abused as children and had recovery issues that related back to resolving these earlier issues. One woman had recently lost her baby to SIDS. All three women were younger than 36 years, Caucasian, and middle class. Two were home with their children and the third was working and 9 months pregnant with her second child.

Permission was requested and granted from the University Institutional Review Board. All interviews were taped and lasted approximately 2 hours. The questions were open-ended and attempted to elicit the following from each participant.

- What it was like to be pregnant and cope with an eating disorder.
- A description of her children and how they were faring.
- Her perception of the recovery process.

Case Reports

Case #1. B is a 35-year-old, married, white female, pregnant with her second child, and mother of a 3-year-

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old girl with eating disorder symptoms of bingeing and purging. B, herself, has had an eating disorder since she was in college. She has been in treatment for 2 years and plans to continue after this next child is born. She has no psychiatric history other than the diagnosed eating disorder. Her childhood included sexual abuse by a brother between the ages of 5–15 and abandonment by her father at age 16 when he discovered he was a homosexual and left the family. B was temporarily separated from her husband after her first child was born, in part due to the severity of her eating disorder. They are now reconciled and she is 9 months pregnant with her second child.

Case #2. C is a 36-year-old, married, white female who has two children, a boy age 4 who has food refusal problems and a girl age 2. C developed her eating disorder in high school. She has been in treatment for a year for her eating disorder. She has no psychiatric history other than her diagnosed eating disorder. Her childhood included family violence between her parents; her father was alcoholic, addicted to pornography, and sexually abusive to her mother. C witnessed physical fights between her parents and discovered the pornography collection at age 5, which she states she looked at frequently for many years. C is having problems with her son who at age 4 frequently refuses to eat and with whom she gets into frequent power struggles over eating.

Case #3. S is a 28-year-old widowed, white mother of a 2-year-old boy and a 6-year-old girl. The 6-year-old is reportedly having difficulties with food refusal issues and concerns about being fat. S resides with a boyfriend and gave birth to her third child, a girl, who died 22 days later of SIDS. S is returning to treatment after having been out of treatment for 3 months. S's first husband committed suicide 3 years ago. Her eating disorder began in high school and S's childhood included sexual abuse by a father when she was between the ages of 6–12.

EATING DISORDERED BEHAVIOR DURING PREGNANCY

Pregnancy rates and outcomes are difficult to establish among women with anorexia and bulimia. Eating disorders may go unrecognized during pregnancy due to inadequate or no screening, failure of the client to inform the health care professional, or the client's denial that a disorder exists (7). The clinical implications for clinicians treating the pregnant woman with an eating disorder are important. Professional nurses and midwives are in ideal positions to carefully screen, refer, and monitor the eating behaviors and concerns of pregnant clients who have an eating disorder.

The lack of recent empirical or large-scale studies makes it difficult to know how pervasive eating disorders are during pregnancy. Three empirical studies cited the most frequently in the literature on eating disorders (12–14) are all over 10 years old and rely on retrospective memory. The evidence from these small studies, however, suggests that eating disordered behavior, while diminished during the course of a pregnancy, is not entirely abandoned. In a study of 20 untreated bulimic women, Lacey and Smith (12) found that bulimic behavior continued during the first trimester and decreased starting in the second trimester, so that by the third trimester, 75% had stopped binging and purging. In almost half of the sample, the symptoms returned soon after delivery and were more severe (12). In another study of 43 women with eating disorders, 70% reported a decrease in behavior during their pregnancies, however, 44% retained some symptoms right up to delivery (14). Stewart et al (13) interviewed 15 women, three with anorexia, four with bulimia, and eight whose symptoms had remitted before conception. The women who were symptomatic during their pregnancies were found to gain significantly less weight and to have infants with smaller birth weights and lower Apgar scores than those whose symptoms had remitted before the pregnancy began (13). The women were symptomatic, continued to be symptomatic during the pregnancy, and worsened after the delivery. Although the numbers in these studies are small, they do suggest that if eating disordered behavior is present at the time of conception, it may continue during the first and second trimester if left undiagnosed and untreated.

> (B) I didn't want to gain too much weight, so I still restricted but I ate healthier foods like nonfat yogurt and vegetables. I didn't gain any weight for the first five months and then my doctor got really worried so I began to eat and I gained 26 pounds in the last three months. I actually loved gaining weight, I really did. I was happy for the first time in my life.
>
> (C) I'd go two or three days without binging and purging, I think I made it for a couple of weeks. . . . I was small and the baby was small. . . . I also had low blood pressure . . . I exercised two, no may be three days a week on the treadmill . . . it's like a constant battle . . . like in my brain . . . the wicked eating disorder talking to me and then the one who wants to get out of it, talking back and forth,

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back and forth. . . . I always made sure I ate something after I purged while I was pregnant.

(S) I was terribly anorexic for a while in the beginning of the pregnancy. I was so afraid to get fat. I knew I had to, it was an awful conflict. I ate next to nothing.

PHYSICAL EFFECTS OF EATING DISORDERS DURING PREGNANCY

The effects of anorexia nervosa and bulimia nervosa on the pregnant woman are similar. Pregnancies complicated by active anorexia or bulimia are at high risk for developing complications (7, 15, 16).

Women with eating disorders appear to be prone to a variety of obstetric complications that are not necessarily due to low weight. Outcome studies have documented increased rates of difficult deliveries, hypertension, breech births, forceps deliveries, miscarriage, vaginal bleeding, decreased uterine size, and cesarean sections (12). Evidence has also been put forth that documents greater perinatal mortality among the babies of eating disordered mothers. Brinch et al (17) followed 50 anorexic mothers who had collectively given birth to 86 children. Seven babies died within 1 week, five from prematurity, one from hydrocephalus, and one from stillbirth; the mortality in this study was six times that of the national rate at the time.

Some research has also examined whether maternal bulimia contributes a teratrogenic risk for the fetus. Certainly, maternal undernutrition is known to be associated with increased perinatal mortality (12). One study found a greater risk of fetal loss through miscarriage in actively bulimic women (18). Overeating and binge eating can lead to excessive weight gain and increase the risk of complications such as preeclamsia and hypertension (19).

Other complications to the babies of eating disordered women, such as cleft palate, epilepsy, and developmental delays have also been reported (18, 20). Since these studies are mostly presented in the form of case reports, prevalence rates of problems are not available.

(B) Well she was breech, and then she was born with severe dairy and egg allergies so she was very, very sick in the beginning. Then at about age two she had a seizure and they put her on anti-seizure medication.

(S) Well I was much better this pregnancy and I had it (the eating disorder) under control, and this baby died of SIDS!

EATING DISORDERED BEHAVIOR AFTER DELIVERY

Although there has been very little empiric examination of eating disorders after pregnancy, recent work (21) suggests that eating disordered behaviors increase markedly in the postpartum period and then plateau over the next 6 months. Stein and Fairburn (21) followed a sample of 97 primigravid women in a general population sample and examined their eating behavior and weight at conception, at 3 months into their pregnancy, once during the third trimester, and again during the immediate postpartum period, and finally, at 6 months postpartum. Concerns with body shape, weight gain, and eating were found to be significantly increased in the immediate postpartum period for the group as a whole, and particularly for the three women who had been diagnosed with eating disorders at the time of conception. In this study, a small number of women developed an eating disorder of clinical severity during the postnatal period (21).

(B) As soon as I could walk after I had her, I started doing exercises again. . . . I just wanted to get the fat off. I was going to the gym 2 or 3 hours a day in the morning, at 3:30 in the morning until 5:30 in the morning or 2 in the morning till 5. Just to get the fat off. I didn't even attempt to breast-feed; I was so focused on losing the weight.

(B) One day I went to the store, and I got candy corn, malted Easter eggs, peeps, gummy bears, bags of those . . . I knew my husband was coming to pick my daughter up for dinner . . . so I couldn't wait for them to leave . . . then I just sat down and just inhaled everything . . . then after, well I knew what I was going to do because I bought the ipecac . . . I think it's the first time I started to freak out when it wasn't working fast enough, so I made myself throw up, and then when it kicked in I felt I was gonna die, because I had already thrown up everything that there was in there . . . then I was heaving, and like heaving blood- . . . then I used laxatives . . . they're going to come home from pizza, and they're going to find me dead on the floor. . . . I think it's the first time I was really scared.

(C) Yeah, well, I was back to binging and purging within weeks of my daughter's delivery. I knew I had to go into treatment . . . I was so moody and irritable.

PARENTING OF WOMEN WITH EATING DISORDERS IN THE POSTPARTUM PERIOD

Children of women with past or current diagnoses of eating disorders are at potentially increased risk for developing eating disorders (22). As is the case with many psychiatric illnesses, the best explanatory model for this phenomenon suggests the interface of genetics, the environment, and psychological factors.

A growing body of research suggests that eating disorders are familial and that additive genetic factors play a role in the familial transmission of anorexia nervosa and bulimia nervosa (22). At the same time, environmental factors such as childrearing problems among mothers who have been afflicted with eating disorders are gradually becoming a topic of attention. All three of the mothers in the case reports described

difficulties with their young children that they related directly to their own eating disorders.

Several studies have examined breastfeeding patterns by mothers with eating disorders. Overall, the findings suggest that women with eating disorders tend to have more difficulties with the process often resulting in early termination and the introduction of bottle feeding (23, 24).

(B) I just couldn't do it. I was so preoccupied with losing weight and tense that I switched her to bottle very quickly.

(C) I breast fed both my children, actually, I was binging and purging so much and so irritable, it was the only way I had to relax.

(S) Breastfeeding? No way. I didn't want to get fat and anyway I was restricting again so my milk dried up fast.

Lacey and Smith (12) report that 15% of the mothers with bulimia nervosa (n = 20) attempted to slim down their babies in the first year of life. Van Wezel-Meijler and Wit (25) conducted a study of children of mothers with anorexia nervosa, and reported seven babies among three families exhibiting symptoms similar to the mother's eating disorder symptoms (25, 26). All seven children exhibited undernutrition and growth delay. Stein and Fairbum (21) report that among five cases of mothers with bulimia nervosa raising children between the ages of 15 months and 6 years, three of the mothers exhibited extreme concern regarding the weight of their children, and attempted to hold down the children's weight. A recent study of young children (ages 1–4 years) of mothers with eating disorders found that these children had significantly lower birth weights and lengths; in addition, mothers had more difficulties maintaining breastfeeding, and they made significantly fewer positive comments about food and eating than control mothers during mealtime observation (24). These investigators suggest that the inability to breastfeed or making fewer positive comments does not necessarily lead to an eating disorder in the child but may contribute to the expression of a genetic predisposition (24).

In another study of children (n = 26) of mothers with eating disorders, 32% of the children had significant abnormalities of weight and growth. Mothers were found to routinely underestimate their children's dietary needs (27). Another recent study that compared preschool age children and mothers with eating disorders and a control group of mothers and children without eating disorders, found that food refusal was associated with children of mothers with eating disorders; however, food fussiness was common among both groups (28). The common psychological and developmental problems that seem to be emerging from this body of literature are presented in Table 1.

TABLE 1
Problems of Mothers with Eating Disorders (ED) and Their Children (27–30)

Mothers with EDs	*Children of Mothers with EDs*
Disturbed perceptions of child's weight, hunger	Food refusal, fussiness, and anxiety
Difficulties with feeding	Simulated vomiting and overeating
Difficulties with own eating symptoms	Concerns for mother's weight
Exposing children to ED symptoms	Underweight and growth delays

(B) My husband and I started to have marital problems, and we were in marital counseling, and one day I just broke down and started crying and said I just can't do this anymore. Because my daughter started to display running to the bathroom to throw up. She started that at 18 months. She would sit and eat and eat and eat until she literally would throw up, because she had seen me doing it . . . as time went on she was still doing it . . . I would sit and watch her, and she would just eat until she threw up. You see at the time I was completely out of control with my own bingeing and purging and M would watch me. She would come into the bathroom and pat my back saying "Mama sick, poor Mama." And then when she started to do it, I would sit on the bathroom floor and cradle her and soothe her. Finally I went for treatment and I started to get my own symptoms under control and then I stopped letting her stuff herself and she would get so angry and cry and cry. I think I put some of my guilt and anger at myself on to her. I wanted her to stop and I suddenly stopped letting her have so much food. It was a hard time. She's still got some problems with it and she's three now.

(B) I used some of the suggestions my therapist had given me by just giving her small amounts of food and telling her when she's finished maybe in a few minutes I'll give you more to see if she can distract herself from the food. She's just starting to improve. In the past I would make a bag of microwave popcorn and I would go to the bathroom and I would come out and she had eaten the whole thing and then she would say, "my belly hurts," I'd say no wonder your belly hurts you just ate five servings of popcorn. She's just starting to get better. I worry that she's fat when she's little, she's going to be obese when she's older. My daughter also has epilepsy so she's on medication for that and a side effect of that is constant feeling of hunger.

(C) No, I never did it in front of the kids. It was my little secret and I didn't want them to know. . . . Well maybe once, my son saw me purge when he was a baby, and I told him I was sick. I think an effect of my eating disorder is dinnertime. He's one not to sit and eat. I felt my pressure on him when he didn't eat and I immediately got upset. I felt a lot of guilt about that. He wouldn't touch his food. I fed him. This started at age two. But if he didn't want to eat I'd get ugly . . . I'd yell at him . . . something I don't want to remember.

(C) I was thinking about the time even last night. He [age 4 years] wouldn't eat, he hadn't had a nap, and he was over tired, he had every reason not to want to eat. I felt all that ugliness and tension inside again, I said okay B no eating, then nose to the wall; that's my way of disciplining him. He really listened, he said "okay mom I'll give you a kiss," then he counts to ten because he knows that when I'm ugly I sometimes scream but I don't scream if I count to ten. This time I told him, if people don't eat they die. He refuses to eat a lot.

(S) Yeah the six-year-old is worried about being fat. She's tiny, and I can't get her to eat and I hear my own doubts in my head, the insecurities; she's going to be like you. I get my own issues mixed up with her sometimes.

INTERVENTIONS FOR PREGNANT AND POSTPARTUM WOMEN WITH EATING DISORDERS

Screening

Many women hide their eating disorders behind walls of shame and secrecy (31). Like sexual abuse, eating disorders are often kept secret so that even those closest to the woman may not be aware of the problem.

(B) I think if they [doctors] suspect something they should ask, and even if they don't get an answer they were looking for because deep down they know it is true, they need to probe a little bit more. I had morning sickness, but I think I was glad I did, so I could not gain the weight . . . probably if I didn't have morning sickness, I still would have been [purging].

(S) With my first no one asked and I didn't tell, I was ashamed.

(C) They didn't ask, but I told them, but then they didn't mention anything after I told them.

Although not all women with eating disorders have been sexually abused as children, the rates of eating disorders are high among clients with a history of childhood sexual abuse (32). A history of childhood sexual abuse may be an additional risk factor for mothers-to-be with eating disorders and is worthy of further research. Certainly, recovery issues from an eating disorder are profoundly affected by a history of sexual abuse as is the emotional trajectory of a pregnancy (33).

(B) My brother sexually abused me for a long time, until I was fifteen, and then I fought back one day and it stopped. I still can't spend much time with him, he's apologized and I've gotten help but it's been hard.

(C) Well, I discovered my father's pornography collection about age 5 and I really got into it for many years think this kind of screwed things up. He and my mom fought a lot and he was not satisfied and I knew it. He would get physical with her and one time he did with me. He drank and never ate with us, he would watch us eat while he drank.

(S) Yeah, there was lot of it [childhood sexual abuse].

Clinically, eating disorders are some of the most frustrating and difficult forms of mental health problems to treat. Denial and resistance to the problem run very high in this group of patients, and eating disordered clients are sometimes unpopular with practitioners because of the perception that clients frequently deny, deceive, and rationalize to protect their symptoms (34). Because of the high level of denial and minimization among these clients, it is imperative that obstetric clinicians should assess carefully, thoroughly, and empathetically. All pregnant women should be screened for a history of eating disorders and childhood sexual abuse (33). Inquiries need to be careful, nonjudgmental, and gentle. Anecdotal clinical reports by women with eating disorders suggest that eating disorders are not routinely screened and asked about in prenatal visits, even when the woman fails to gain weight in the first trimester. When discussing eating disorders with a pregnant woman, it is helpful to get clear details about the eating patterns and attitudes of the woman and her attitudes toward her body and sexuality.

Embedded in a person's perceptions of health and illness are metaphors and language created to explain, engage, and sometimes dismiss illness (35). Health care providers are in a unique position to explore the meanings of "feeling fat" and "being pregnant" and then can develop a meaning centered interpretation of eating disordered symptoms. The power of using the client's own ideas, images, metaphors, and language to communicate is widely recognized as a helpful therapeutic strategy when interviewing, assessing, and treating clients with health issues. Nowhere is this truer than with clients with eating disorders (34).

Sometimes, sensitive questioning alone may be therapeutic in attenuating inhibition because the patient has never been given permission to address her concerns. Encouraging honest expression, validating fears, and giving the message that it is possible to take care of herself and her baby may provide a unique window of opportunity for the practitioner to correct misconceptions and dissolve denial (31). Identifying clues to triggers or what sets the eating behaviors off is helpful. The obvious observation that the woman is not gaining weight may be the most obvious clue.

There are several eating disordered inventories that can be used as quick assessment tools and should be available for those involved in prenatal screening for patients (32); however, these alone should not be used without careful questioning.

Referring the pregnant woman with an eating disorder to an ED specialist at this time is also critical. Eating

TABLE 2
Treatment Recommendations for Pregnant Women With Eating Disorders*

- The eating behaviors of pregnant anorexic and bulimic patients should be carefully screened and monitored. Assessment tools such as the Eating Disorder Inventory should be used for more detailed screening.
- The clinician should confront denial; limit the restrictive eating, binging, or purging; and promote healthy eating patterns. It may be beneficial to make the fetus as real as possible to the woman very early so that she can connect her problematic eating to the fetus growing inside her. Referral for therapy to an eating disordered specialist is helpful.
- The client's fears of weight gain and feelings of being out of control should be empathetically addressed.
- The posting of educational or informational flyers on eating disorders in obstetric offices may encourage women to seek help. The flyer may entice women if they know that confidential help is available and they are not suffering alone.
- Postpartum screening is very important. Clinicians need to screen for return of eating disordered behaviors and fears. Screening for depression would also be relevant.
- Early intervention with the mother-infant dyad may be necessary. The clinician should assess the nursing and feeding issues with the new baby and refer for therapy if necessary.
- Communication with the clients pediatrician or CNS might be helpful.

* As research in this area is still in its infancy, longitudinal studies of babies of women with active eating disorders would be important.

disorders clinics often have a full range of services that include psychiatric, nutritional, and family resources (5).

Treatment will usually focus on the modification of dietary habits and on concerns about shape and weight. Psychoeducation by eating disorder specialists that is beneficial to clients with eating disorders includes information on the physical and psychological aspects of restrictive eating, binging, purging, and low weight status; the properties of foods and the parts of a balanced diet; the factors involved in appetite and energy expenditure; genetic influences on body weight and metabolism, exercise mythology, and physiology; and the complex relationships between weight, shape, and diet and a variety of health risks (34, 36). The cost/benefits of change must be examined, and this is a time when the cost/benefits to the fetus must be included in the dialogue.

Prenatal Interventions

Once a woman has disclosed a history of eating disorders, the practitioner has the opportunity to be especially sensitive to her needs during any interaction, procedure, or examination. It is vital to help her by discussing her fears of gaining weight and the importance of this weight to the baby's growth and development. Helping to make the patient the expert about her symptoms can be supportive and validating. The notion of empowering the woman to be the authority of her own care, to develop a vocabulary for the message conveyed in bodily terms, and to construct a narrative that captures her struggles and focuses on recovery parallels principles of feminist care (37). One of the participants described her struggle between the "wicked eating disorder" voice in her head and the other voice, the one that counters it; one might give name to the other voice and help her to describe the healthy voice in more detail, and give it a stronger, richer identity.

Developing healthy routines for exercise and diet and identifying healthy foods that the woman herself wants to eat are important. Having a support person eat with her and making a commitment to abstain from purging after meals is vital. Allowing the woman as much control as possible is critical.

Postpartum

Similar to the women described previously, issues connected with eating may reoccur after delivery for many women with eating disorders. Losing weight becomes the goal once again and the woman may re-exhibit disordered behavior. Screening for the return of eating symptoms and depression should be done. Eating disorders have a high rate of comorbidity with depression (22).

As indicated in these case reports, stabilization of the eating disorder may take several years after delivery so that making referrals to eating disorder specialists as early as possible for treatment is vital. As with the women described in the case reports, however, some women with eating disorders clearly make a serious effort to stop their symptoms after they have children because they do not want to pass these behaviors on to their children. This should be seen as a period of high motivation and potential for treatment.

These case reports and the available research suggest that the perinatal period may also be a time of difficulty for mothers with eating disorders when it comes to feeding their children. Young children may become symptomatic themselves. A recent study of a sample of British psychiatrists who routinely treat women with eating disorders found that the majority of the doctors in the study had little knowledge of the risks for the children of their clients with eating disorders and the majority did not assess or treat their eating disordered patients' families or children (38). For this reason, screening related to the mother infant feeding and bonding should be performed. Anorexia and bulimia are known to

express themselves differently in children as compared to adolescents and adults. Treatment needs to be tailored to the unique developmental age of the child (39). In light of current findings, recommendations for treatment are provided in Table 2.

CONCLUSION AND TREATMENT IMPLICATIONS

This article has presented three case reports of women with eating disorders who became pregnant, remained symptomatic for much of their pregnancies, and went on to resume eating disordered behavior in the immediate postpartum period and for several years thereafter. All three women reported having young children with eating disorders, from toddlers to age 6 years.

Eating disorders during pregnancy and the postpartum period can have far-reaching, adverse effects on the mother and child if the ED goes undiagnosed and untreated. Both mother and child may become victims of an eating disorder and a transgenerational phenomenon may begin. Practitioners are in a unique position to be able to screen, refer, and monitor these women at all stages of their pregnancy.

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