Running head: DISORDERED EATING AND PREGNANCY

Disordered Eating and Pregnancy: Counselling Treatment Recommendations

Final Project Letter of Intent

Christina Vaillancourt

Supervisor: Dr. Gina Wong-Wylie

February 15, 2007

Campus Alberta Graduate Program
Problem Statement

Eating disorders have become one of the most prevalent psychiatric issues for women (Newton & Chizawsky, 2006). Eating disorders, such as bulimia nervosa (BN) and anorexia nervosa (AN), are not typically associated with pregnancy. However, women with BN or sub-threshold AN can experience menstrual regularity, making pregnancy a viable and vulnerable experience. Women who were born after 1960 are at a greater risk of developing BN, and these women are in the age range for childbearing (Kendler et al., 1991). In addition, eating disorders beginning in adolescence can persist into adulthood, a time when women will bear children (Seiden, 2005).

To date, few treatment approaches for pregnant women suffering from disordered eating have been formalized. Franko (2006) offered empirically informed treatment guidelines that may help mental health and obstetric health care providers in optimizing maternal and fetal outcome. However, this project aims to examine and create a comprehensive set of guidelines for counsellors to follow when working with pregnant women with disordered eating. Understanding the course of pregnancy, the etiology of various eating disorders, and predisposing social and cultural factors, are critical aspects to developing treatment guidelines for this population.

Rational for the Project

Eating disorders, such as AN and BN, are associated with serious psychological, psychosocial, and physical outcomes (Seiden, 2005). A minimal amount of research exists outlining the effects of eating disorders on pregnancy; however, the available evidence suggests that there are detrimental consequences for both the mother and the fetus when a
pregnant woman has an eating disorder (Franko, 2006). Specifically, Seiden reported that eating disorders during pregnancy can result in miscarriage and obstetric complications. Behaviors that are characteristic of eating disorders, such as low pre-pregnancy weight, are associated with low infant birth rate (Morrill & Nickols-Richardson, 2001) and a higher incidence of congenital malformations (Lacey & Smith, 1987). Considering this, it is important for mental health clinicians to be aware of the possible dangers of disordered eating behaviors during pregnancy as maternal and fetal health may be jeopardized.

Despite the detrimental health implications, relatively little is known about the relationship between eating disorders and pregnancy (Mazzeo et al., 2006). Clinical researchers have confirmed that women with eating disorders are indeed having children (Carter et al., 2003; Franko et al., 2001; Little & Lowkes, 2000; Morgan, Lacey, & Sedgwick, 1999). Consequently, pregnancy and motherhood has received much attention among eating disorder researchers (Blais et al., 2000; Carter et al., 2003; Franko et al., 2001; Morgan et al., 1999; Mitchell-Gieleghem, Mittelstaedt, & Bulik, 2002). There is a dearth of research examining interventions to support pregnant women with eating disorders. The proposed project will contribute to filling this gap in the professional literature. I will conduct a thorough review of the literature to identify the unique needs of pregnant women suffering from disordered eating, and critically evaluate and compile this information to develop a set of counselling treatment recommendations.

Purpose

Within this Letter of Intent, I aim to develop treatment recommendations for pregnant women suffering from an eating disorder. Specifically, in this final project, I will:
1. Examine the literature and research pertaining to the impact of pregnancy on eating disorder symptoms and the impact of eating disorders on the course of pregnancy and outcome.

2. Critically analyze and synthesize current interventions for treating disordered eating during pregnancy and postnatally.

3. Include the development of counselling guidelines for mental health practitioners to apply in working with pregnant woman suffering with an eating disorder.

4. Explore the potential implications of the final project, including who will benefit from this project.

Supporting Literature

Clinical eating disorders include AN, BN, and eating disorders not otherwise specified (EDNOS). The current definition of AN is given in the fourth edition of the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR), and has four criteria: (a) refusal to maintain normal body weight ad weight that is 85% or lower than expected for age and height; (b) extreme fear of gaining weight or becoming overweight, even when underweight; (c) disturbance in the way in which one’s body shape or weight is experienced, intense influence of body weight or shape in self-evaluation, or denial of the seriousness of the current low body weight; and (d) loss of menses for three months, or never getting menses (APA, 2000). BN is defined by (a) recurrent episodes of binge eating twice weekly for three months with loss of control, (b) recurrent inappropriate compensatory behavior (e.g., excessive exercise or vomiting) in order to prevent weight gain; and (c) self-evaluation that is influenced too much by body weight
and shape (APA, 2000). The EDNOS category is for individuals who have an eating disorder that do not meet the criteria for either AN or BN (Gilbert, 2005).

For the purposes of this project, an eating disorder is operationalized as that which meets the DSM-IV-TR criteria for AN, or BN, or EDNOS. As the purpose of this project is aimed at investigating eating disorders during pregnancy, adjustments to how eating disorders are clinically defined are necessary. There are specific DSM-IV-TR criteria for eating disorders that are not applicable to most pregnant women, such as amenorrhea (e.g., the absence of at least three consecutive menstrual cycles), and purging behavior (e.g., self-induced vomiting). It is understood that many women experience nausea and vomiting during their pregnancy, and this is not to be confused with purging behavior.

Personal, behavioral, and socio-economic factors, such as low self-esteem, negative body image, fear of becoming fat, and social pressures to be thin, have been identified as risk factors for developing an eating disorder (Jarry, 1998; Steiger, Gauvin, Jabalpurwala, Seguin, & Stotland, 1999). As the symptoms of AN and BN involve behaviors and attitudes related to food and weight, it is understandable that pregnancy, with increased caloric needs and body weight, might be problematic for women suffering from disordered eating (Franko, 2006).

Impact of pregnancy on eating disorder symptoms

Empirical literature outlining the effects of disordered eating symptoms during pregnancy is limited as many published studies are retrospective and have been conducted using relatively small sample sizes (Franko, 2006). The few studies that have examined the changes in women’s disordered eating during the transition into motherhood have yielded mixed results. Many researchers have found that pregnancy leads to symptom remission in many women. In one of the few prospective studies to examine the impact and outcome of
pregnancy, Blais and colleagues (2000) found that women with eating disorders generally experienced a decrease in the severity of their symptoms. Similarly, Morgan and colleagues (1999) found that bulimic symptoms improved throughout pregnancy. These two studies suggest that improvement in eating disorder symptoms is limited to the period of pregnancy, but that many women return to eating disorder symptoms after giving birth. It is important to note that some women remain symptomatic throughout pregnancy. At this time, there is no way to predict whether symptoms will remit or continue during pregnancy (Franko, 2006).

The reasons for improvement of disordered eating symptoms during pregnancy are not fully understood. Morgan and colleagues (1999) found that women reported an alleviation of a sense of responsibility for body weight and shape. In addition, physiological changes during pregnancy, such as changes in taste and smell and changes in satiety may have important influences on eating behavior (Fairburn, Stein, & Jones, 1992). According to Mitchell-Gieleghem and colleagues (2002), a woman’s desire to protect the fetus or not harm the baby can contribute to symptom improvement. Although many women with disordered eating feel that they are not worthy enough to eat, they believe their babies do deserve to eat. However, after the baby is born, the perception of a legitimate reason to eat no longer exists. Therefore, the improvement in symptoms can be limited to the length of the pregnancy. The woman’s eating disorder, and her desire for slimness, may become acute in the postpartum period and childbearing stages. If other affective disorders, such as depression, are present, the mother may face serious challenges as she enters the postpartum period.

Pregnancy can be a major challenge to any woman’s body weight and body image (Abraham & Llewellyn-Jones, 2001). Nevertheless, binge eating can occur during pregnancy, and approximately 7% of women who have never suffered from an eating disorder this may
be the first time they have experienced disordered eating symptoms (Abraham & Llewellyn-Jones, 2001). Hollifield and Hobdy (1990) found that the first trimester was a particularly difficult time for women with bulimia as they were inclined to associate their weight gain and body changes with appearing obese. These researchers noted that this association increased on an emotional level when women are weighed at each pre-natal visit. According to Abraham and Llewellyn-Jones, binge eating is more common in the second half of pregnancy. This is the time when the fetus is growing quickly and placing increased demands on the mother for nutrients. Other triggers for binge eating during pregnancy may include boredom, anxiety about the future, and being preoccupied with thoughts of food (Abraham & Llewellyn-Jones, 2001).

Although many studies examining the course of eating disorder symptoms during pregnancy have noted significant improvement in bulimic symptoms, in most cases there was a return to pre-pregnancy symptom levels or worsening of symptoms in the postpartum period (Mitchell, Seim, & Glotter, 1991; Morgan et al., 1999; Abraham, 1998). Research in this area is critical, due to the health risks for the developing fetus, and the fact that women with bulimia tend to have a higher risk of developing affective disorders, such as depression, after pregnancy (Abraham, Taylor, & Conti, 2001; Blais et al., 2000; Franko et al., 2001). Kouba and colleagues (2005) have argued that pregnant women with past or active eating disorders should be recognized as at-risk patients during pregnancy.

**Postpartum Issues**

The period after delivery can be very stressful for a woman with an eating disorder. The additional stress of her weight gain during pregnancy, disordered eating symptoms, and new feeding demands can pose significant challenges during the postpartum period (Franko,
One issue of serious concern is postpartum depression (Franko & Hilsinger, 1995). Women suffering from bulimia or anorexia are more likely to seek counselling for distress and depression in the year after the birth of their child (Abraham & Llewellyn-Jones, 2001). Abraham and Llewellyn-Jones found that women who are most at risk for postpartum mood disorders are more likely to use dangerous methods of weight control such as binge eating or self-induced vomiting. According Wonderlich and Mitchell (1997), approximately 40% of women with eating disorders have a history of affective disorder, which also contributes to their risk of developing postpartum depression (O’Hara, Schlechte, Lewis, & Wright, 1991).

Description of the Method and Procedures

Adhering to a feminist approach, this project will provide an overview of the literature and research conducted in the area of pregnancy and disordered eating. The product of this review will be a list of counselling treatment recommendations for this population. The list of recommendations will be designed specifically for pregnant women who have AN, BN, or a sub-clinical eating disorder prior, during, or after pregnancy.

There are two major steps required prior to developing the treatment recommendations. First, a thorough review of the literature regarding the effects of eating disorders on the course and outcome of pregnancy must be conducted. In addition, an extensive evaluation of the research examining various interventions used in treating eating disorders needs to be completed. The review of this research and literature will help inform the treatment recommendations. Electronic databases that will be utilized for the literature review include Academic Search Premier, MetaPress Taylor & Francis, PsycINFO, PsycBooks, and Medline, from 1990 to the present in English. Some key words to include in the literature review are eating disorders, pregnancy, coping, symptoms, counselling, and
treatment. Once a significant amount of research is located, I will prepare a critical synthesis of the literature to integrate into the project.

Second, I must identify and locate any existing resources that are similar in nature to the counselling guidelines I intend to create. This will ensure that there is no duplication of service. Once these two steps are completed, I will begin to develop the counselling treatment recommendations.

Potential Implications

This project will primarily benefit pregnant women who may be at risk for a concurrent eating disorder. As suggested by the experts in the field, an eating disorder may constitute a serious health risk during pregnancy and the childbirth period. The counselling treatment recommendations will provide support for women coping with issues related to their disordered eating symptoms and pregnancy. Lastly, this final project will provide a means of understanding the impact of eating disorders on pregnancy course and outcome, as well as the impact of pregnancy on eating disorder symptoms. Such information will improve the practice of counsellors who treat pregnant women with an eating disorder.
References


