Understanding eating disorders in the antenatal and postnatal periods

Dr Abigail Easter, NCT senior research and evaluation officer, explores the evidence on unhealthy attitudes to food during pregnancy and after birth, and how women can best be supported.

What are the characteristics of eating disorders and how common are they?

Eating disorders include a range of conditions which can have profound physical, psychological and social effects. At a general level they can be understood as a combination of an unhealthy attitude towards food and a distorted body image (e.g. seeing yourself as overweight while being underweight), resulting in drastic changes in eating habits and behaviours. There are three main specific eating disorders: anorexia nervosa, bulimia nervosa and binge eating disorder (i.e. eating a large amount of food in a short period of time).

Although there is great variation in the reported prevalence of eating disorders, it is estimated that approximately 8-10% of females are affected during their lifetime. Approximately 4.6% of women are currently diagnosed with a non-specific form of eating disorder — eating disorder not otherwise specified (EDNOS). Anorexia nervosa (0.6-2.2%) and bulimia nervosa (0.9-1.7%) are less common. Due to recent changes in how eating disorders are diagnosed, up-to-date figures on how many women have binge eating disorder are not available, but earlier data suggest that around 1.6% of the population may be affected.

How many women have eating disorders during pregnancy?

It is sometimes thought that the number of women with an eating disorder who become pregnant is likely to be low due to reduced body weight and menstrual abnormalities often associated with the illness. However, recent research suggests they are more common during pregnancy than previously thought.

In a study undertaken at King’s College Hospital, London, 739 women completed an anonymous screening measure for eating disorder at routine antenatal appointments. The study found that eating disorders affected up to 7.5% of the women screened during the first trimester. The majority of women who met criteria for an eating disorder were diagnosed with EDNOS (5%), with a much smaller number being identified as having anorexia nervosa (0.5%) or bulimia nervosa (0.1%). Binge eating disorder was also common (1.8%), yet little is known about pregnancy in this group and more research is needed.

How do eating disorders affect pregnancy and motherhood?

For women with eating disorders, weight and shape are often the key characteristic by which they evaluate their self-worth and identity. The transition to motherhood is unique in terms of the multitude of changes to a woman’s body and self-identity, which can be particularly difficult for someone experiencing an eating disorder. Although the majority of women affected during the antenatal period are likely to have had an eating disorder previously, pregnancy may trigger the illness for some. However, research is currently lacking to determine how frequently this occurs.

During pregnancy women have described feelings of social and emotional isolation, and a lack of psychological support. The early stages of pregnancy may be the most challenging, as women struggle to accept changes to their body. During the later stages, eating disorder symptoms have been shown to decrease, though high levels of depression and anxiety remain more common.

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Current research evidence suggests that eating disorders may also affect birth outcomes, including increasing the risk of miscarriage, gestational diabetes and premature birth. Although few studies have been large enough to explore whether the different types of eating disorders affect birth outcomes differently, there is some evidence this may be the case. For example, anorexia nervosa has been associated with intrauterine growth restriction and babies that are small for gestational age. A recent meta-analysis found that the birth weight of babies born to women with anorexia nervosa was 0.19kg (6.7oz) lower compared to women without an eating disorder.

In contrast, findings from a Finnish hospital found that women with binge eating disorder were three times as likely to have a baby that was large for gestational age compared to women without an eating disorder (9.6% vs 2.5%). The postnatal period is a time of increased risk for recurrence of eating disorder symptoms that have reduced during pregnancy, and around one third of women with bulimia nervosa may experience depression after birth. Women may also have difficulties with breastfeeding and family mealtimes during childhood.

How can women with eating disorders be supported and treated?

Pregnancy can pose challenges to the accurate identification of eating disorders. Features of pregnancy such as weight gain, changes in appetite, nausea and vomiting can mask an eating disorder. Given the typical, but often temporary, reduction in symptoms during pregnancy, they can remain hidden. This makes it difficult for healthcare providers in antenatal settings to identify eating disorders, and offer support or treatment.

A crucial element to providing appropriate support and treatment is improving awareness of the characteristics and prevalence of eating disorders during pregnancy. It is important to recognise that women with eating disorders may find it difficult to discuss their illness in antenatal settings due to fear of stigma or that services might respond in a negative way. However, many women are highly motivated during pregnancy to change their behaviours, and active and supportive listening may help women to begin to discuss their illness in a safe environment. Encouraging women to speak to their midwife or GP about their mental health can enable them to gain appropriate support from perinatal mental health services, where available.

NICE guidelines suggest that pregnant women with an eating disorder may need more intensive antenatal care. They should also be followed up closely after birth due to the potential for relapse, increased risk of postnatal depression and potential problems with breastfeeding. Women with eating disorders are often very unsure about appropriate dietary intake and nutritional requirements, so providing women with this information can be a useful addition to mental health care.
Practitioners – remember the three Ls!

- **Language** – Watch and reflect on language you and others use that might be distressing or feel judgemental for people with an eating disorder, e.g. ‘Don’t worry about feeling a bit unattractive.’ Reflect on the information in this article and talk it through with colleagues.
- **Listening** – If a woman or her partner wants to talk about fears around food, it is useful to know that talking to practitioners and health professionals in a safe and uninterrupted setting can be beneficial. A continuing relationship with a kind and compassionate person really can make a positive difference. However, it is important to signpost a parent to her midwife or GP if you are concerned.
- **Lunch** – If NCT support activities involve food, this could be overwhelming or feel like an obstacle to participation. It might help if branches consider offering some activities that are not centred around food, such as going for a walk, meeting up to do baby massage or play.

Further support

Beat (Beating Eating Disorders) is a UK-based charity which provides helplines, online support and a network of UK-wide self-help groups for individuals with eating disorders (www.b-eat.co.uk).

References


Eating disorders – recognising the signs

**Anorexia nervosa**
- Severely reduced food intake and significantly low body weight
- An intense fear of gaining weight or becoming fat
- A distorted body image
- Body weight or shape has a strong influence over feelings of self-worth

**Bulimia nervosa**
- Regular episodes of binge eating combined with recurrent ‘compensatory behaviours’ (e.g. self-induced vomiting or misuse of laxatives)
- Body weight or shape has a strong influence over feelings of self-worth

**Binge eating disorder**
- Regular episodes of binge eating, which are not associated with the use of ‘compensatory behaviours’ described above
- Physical or psychological distress such as disgust, depression or guilt following binge eating

For common warning signs and symptoms which you or other parents might notice, go to: www.nedc.com.au/recognise-the-warning-signs.