Eating Disorders and Pregnancy:
Supporting the Anorexic or Bulimic Expectant Mother

Abstract
Eating disorders have been on the rise since the 1980s. For a woman previously treated for an eating disorder such as anorexia or bulimia, a pregnancy may exacerbate prior symptoms. Women with an eating disorder may also be embarrassed by or reluctant to reveal prior or current symptoms to healthcare providers. This article presents a case study of an expectant new mother with a history of anorexia. The information will help nurses become more alert to predisposing factors that may indicate a potential problem with an eating disorder, and provide practical ways to help these women cope with their anxiety about their changing bodies. As a result, nurses can help these women maintain a healthy pregnancy with a good neonatal outcome.

Key Words: Anorexia; Eating disorders; Pregnancy.
Pregnancy is a time when women must adjust to changes in their bodies. For women with a prior history of eating disorder, however, adjustments can be more difficult, and eating disordered behaviors from previous years may return (Koubaa, Hallström, Lindholm, & Hirschberg, 2005; Mitchell-Gieleghem, Mittelstaedt, & Bulik, 2002). For some women, the stress of pregnancy and facing parenthood produce an uncontrollable urge to restrict their weight gain (Patel, Lee, Wheatcroft, Barnes, & Stein, 2005). If she has not fully recovered from an eating disorder, it is crucial for the woman to get her eating disorder under control once she becomes pregnant.

Eating disorders in pregnancy have been associated with poor outcomes for both the mother and her baby, including miscarriage/stillbirth, hypertension, cesarean birth, low birthweight, fetal abnormalities, low Apgar scores, breech presentation, forceps birth, cleft lip and palate, increased risk of bleeding during and after birth, and healing problems after lacerations or episiotomy (Brinch, Isager, & Tolstrup, 1988; Franko et al., 2001; Gura, 2007; James, 2001; Koubaa et al., 2005). Women with a history of an eating disorder are also at a higher risk for developing postpartum depression (Franko et al., 2001; Gura, 2007; Patel et al., 2003).

Eating Disorders

According to the National Eating Disorder Association (NEDA), almost 10 million females and 1 million males in the United States suffer from eating disorders such as anorexia and bulimia, and millions more suffer from binge eating. More than one-third normal dieters develop pathological dieting (http://www.nationaleatingdisorders.org/in-the-news/index.php).

Extremes characterize eating disorders. The presence of an eating disorder can be discerned when a person experiences intense preoccupation and distress regarding body weight, size, or shape to the point of drastically reducing food intake, overeating, or exercising excessively. Eating disorders are multifaceted, typically beginning with dieting, overeating, or eating smaller or larger amounts of food than normal. In time, this pattern of behavior begins to spiral out of control. A person suffering from an eating disorder may engage in a variety of activities to purge the food consumed. The sufferer may restrict or reduce food intake or exercise excessively to burn calories. Although the biology, genetics, behavioral, and social components of this illness have been of interest to researchers since the 1970s, no etiology has been found, and there has yet to be substantial progress in understanding the disorders or the best treatments (Augustyn-Lawton, 2009; Patching & Lawler, 2008).

According to the Diagnostic and Statistical Manual of Mental Disorders (4th edition) (American Psychological Association, 2000), eating disorders are characterized by a critical disturbance in eating activities. The disorders comprise three categories: anorexia nervosa, bulimia nervosa, and eating disorder not otherwise specified with subtypes in each.

Symptoms of anorexia nervosa include:
• refusal to maintain a normal body weight for the individual's height and age
• intense fear of gaining weight
• distorted image of body weight or shape.

Most women with this disorder are amenorrheic. They typically weigh less than 85% of that classified as normal for their age and height. The two subtypes of anorexia are (1) the restricting type, wherein certain types and amounts of foods are strictly limited, and (2) binge eating or purging (or both), wherein they engage in a variety of purging methods such as self-induced vomiting, laxatives, diuretics, or enemas. The anorexic woman usually sees her condition as a triumph rather than a problem. This condition is sometimes associated with depression or obsessive-compulsive disorder (Augustyn-Lawton, 2009; Costin, 2007; Gura, 2007). Diagnosis criteria for various eating disorders are listed in Table 1.

The characteristics of bulimia nervosa include:
• two or more episodes of binge eating per week for a period of three months
• followed by purging either with self-induced vomiting or with the use of diuretics or laxatives.

Bingeing is the consumption of excessive amounts of food, much more than what the average person would consume in a similar situation. The kind of food fluctuates; however, it typically includes high-calorie foods and sweets. These patients are completely powerless about what they are doing and have little or no control over their behaviors. Women suffering from bulimia nervosa may be of normal weight, underweight, or even slightly overweight. Unlike the women suffering from anorexia, bulimics are typically distraught and embarrassed by their illness. The subtypes include purging, with the misuse of laxatives, diuretics, and enemas as well as self-induced vomiting, and nonpurging, using fasting and excessive exercise to deplete calories (Augustyn-Lawton, 2009; Costin, 2007; Gura, 2007).

Case History

Felicia was diagnosed with anorexia nervosa during her teenage years. She stated that she could not remember ever having a normal menstrual cycle. She used oral contraceptives for at least 10 years before she married at age 27. Felicia claimed successful treatment for anorexia nervosa after several years of therapy; however, she still considered her relationship with food somewhat “stressful.”
The woman may also have a difficult time maintaining her to have irregular or no monthly cycles (James, 2001). Women who have suffered from an eating disorder in the past often have experienced years of starvation, bingeing, and purging. Becoming pregnant can be difficult due to the past often having experienced years of starvation, bingeing, and purging. For the bulimic woman, some of these rituals may include binge eating and purging, abuse of diuretics and laxatives, and excessive exercise (Mitchell-Gieleghem et al., 2002). These rituals can harm her and her baby without adequate diagnosis and treatment, and cause an overall decline in health and wellness, as well as a threat to the reproductive cycle. During pregnancy, the developing fetus depends on the mother for nutrients. When proteins, fats, carbohydrates, vitamins, and minerals are too low, the body may attempt to compensate the mother in order to support the growing fetus. If the mother does not restore the nutrients, she can become malnourished, compromising herself as well as the baby (Anderson & Ryan, 2009; Franko et al., 2001; James, 2001; Mitchell-Gieleghem et al., 2002). According to The American Congress of Obstetricians and Gynecologists’ (ACOG’s) (2009) report on pregnancy and weight gain, a woman with a normal pre-pregnancy BMI, which is a measure of body fat that is based on height and weight, should expect to gain between 25 and 35 lb during pregnancy. According to the CDC (2008) the recommended weight gain during pregnancy should be based on a woman’s height and pre-pregnancy weight with a calculated BMI. Less than 15 lb is too low and not recommended, despite the woman’s height and pre-pregnancy weight. The CDC weight gain recommendations are pre-pregnancy BMI of below 19.8 (underweight), a weight gain of 28 to 40 lb; a pre-pregnancy BMI of 19.8 to 26 (normal weight), a weight gain of 25 to 35 lb; a pre-pregnancy BMI of 26 to 29 (overweight), a weight gain of 15 to 25 lb; and a pre-pregnancy BMI of greater than 29 (obese), a weight gain of approximately 15 lb. Women who gain below these recommended amounts are at risk for giving birth to a low birthweight baby.

For most women, these recommended weight gains are appropriate for a healthy pregnancy. However, for the woman with a prior or current eating disorder, weight gain can produce tremendous stress and be, in a word, terrifying. Some women have a revelation, or change of heart, when they discover they are pregnant and sacrifice their own issues with food for the safety of their child. This can begin the process of the expectant mother overcoming her deeper psychological issues. As she begins to think more about the baby, her eating disorder diminishes in importance. This is the ideal time for her to enter or continue with therapy. Pregnancy is what

Felicia’s pre-pregnancy weight was 110 lb, and her height 5 ft 6 in with a body mass index (BMI) of 17.8, which is slightly below the recommended healthy BMI of 18.5 to 24.9 as recommended by the CDC (2008). She stopped taking oral contraceptives during the first few months of marriage in an effort to establish a healthy menstrual cycle. Despite attaining more acceptable weight, her periods never returned. Obstetrical healthcare providers told her to eat three meals a day and limit her exercise to no more than 45 minutes of cardiovascular aerobics, three to four times per week. Felicia turned to fertility specialists and after 18 months, she finally conceived.

Felicia came to see a nurse practitioner in psychiatry (NPP) for therapy when she was beginning her second trimester of pregnancy with a fear of gaining too much weight during her pregnancy and not being able to lose the weight afterward.

Eating Disorders and Pregnancy

Women who have suffered from an eating disorder in the past often have experienced years of starvation, bingeing, or purging. Becoming pregnant can be difficult due to the ongoing hormonal and dietary imbalances that caused her to have irregular or no monthly cycles (James, 2001). The woman may also have a difficult time maintaining and carrying the pregnancy to term without complications. She may be deficient in calcium, salts, and minerals, and her hormones and neurotransmitters may be so out of balance that her signals for hunger and satiation are not precise. She may not be fit enough, physically or emotionally, to support a pregnancy and will need psychological support (Gura, 2007; Mitchell-Gieleghem et al., 2002; Patel et al., 2005).

Whether or not she has a history of an eating disorder or the less critical “disordered eating,” the expectant mother has certain rituals or “quirks” surrounding food consumption and weight. Some of these rituals for the anorexic woman may include food restrictions, excessive exercising, fasting, induced vomiting, purging, laxative, and/or diuretic abuse (Mitchell-Gieleghem et al., 2002). For the bulimic woman some of these rituals may include binge eating and purging, abuse of diuretics and laxatives, and excessive exercise (Mitchell-Gieleghem et al., 2002). These rituals can harm her and her baby without adequate diagnosis and treatment, and cause an overall decline in health and wellness, as well as a threat to the reproductive cycle. During pregnancy, the developing fetus depends on the mother for nutrients. When proteins, fats, carbohydrates, vitamins, and minerals are too low, the body may attempt to compensate the mother in order to support the growing fetus. If the mother does not restore the nutrients, she can become malnourished, compromising herself as well as the baby (Anderson & Ryan, 2009; Franko et al., 2001; James, 2001; Mitchell-Gieleghem et al., 2002).

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Table 1

<table>
<thead>
<tr>
<th>Women with eating disorders might present with the following symptoms:</th>
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<tbody>
<tr>
<td>• Being unrealistic about her weight and shape despite unusual thinness.</td>
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<tr>
<td>• Very thin appearance with a troubling concern about weight gain.</td>
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<tr>
<td>• Using unnatural and potentially dangerous methods of eating and weight loss, such as starvation, excessive exercise, food restrictions, and purgatives.</td>
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<tr>
<td>• A history of amenorrhea, infertility, recurrent miscarriage, or poor pregnancy results.</td>
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<tr>
<td>• Other physical signs, including dental problems, esophagitis, chronic sore throat, digestive issues such as reflux or bowel problems, and general complaints of fatigue, backache, or leg cramps, which could be due to early signs of osteopenia or osteoporosis due to malnutrition.</td>
</tr>
<tr>
<td>• Emotional symptoms such as anxiety, low self-esteem, and altered body image.</td>
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<tr>
<td>• History of depression, bodily harm, or a suicide attempt (Steen, 2009).</td>
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<tr>
<td>• Reluctance to share their disorder with others, especially healthcare providers. They are either embarrassed or ashamed to reveal their past or current illness, or they may be afraid that, while they are pregnant, their healthcare provider will force them to gain more weight than they would like.</td>
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Eating Disorders and Pregnancy

Women who have suffered from an eating disorder in the past often have experienced years of starvation, bingeing, or purging. Becoming pregnant can be difficult due to the ongoing hormonal and dietary imbalances that caused her to have irregular or no monthly cycles (James, 2001). The woman may also have a difficult time maintaining and carrying the pregnancy to term without complications. She may be deficient in calcium, salts, and minerals, and her hormones and neurotransmitters may be so out
propels these eating disordered victims “out of the closet” (Gura, 2007, p. 125).

Many clinicians suggest that patients with a history of eating disorders who want to become pregnant need to resolve with a therapist their issues related to eating prior to conception (Augustyn-Lawton, 2009; Gura, 2007). Once they become pregnant, it is important to inform their obstetricians or midwives of their prior or current struggle with food and to have close monitoring related to nutrition during the prenatal period. Occasionally, hormones that are present during the pregnancy can have a healing effect on an eating disorder, and some women with eating disorders actually improve during pregnancy (Harris, 2010). Pregnancy can have a wide-ranging effect on an eating disorder. One aspect of clinical management of an eating disorder in pregnancy is a multidisciplinary treatment approach in collaboration with other professionals in related fields (Chizawsky & Newton, 2007).

Felicia stated she was beginning to feel physically and emotionally weighty. She was entering her second trimester and was beginning to show. These feelings compelled a re-emergence of her eating disorder behaviors. She began eating less and exercising more. She was fearful and concerned about the baby receiving the correct amount of nutrients.

The NPP immediately encouraged her to call the nutritionist she had seen in the past for her anorexia. Felicia was not in the habit of eating breakfast. The nutritionist advised her to have a protein shake in the mornings, eat three meals a day, and limit her cardiovascular workouts to three times per week for no more than 30 minutes.

Felicia went to therapy on a weekly basis to work on the link between her eating disorder and her underlying issues with relationships. There they utilized a combination of interpersonal psychotherapy and dialectical behavior therapy that focused on skill building in the areas of nutrition and weight. They worked extensively on mindfulness, ways to quiet her mind, and making decisions based on her instincts rather than reacting from an emotional place. They also explored her destructive behaviors and discussed the fact that these behaviors are not solutions to long-term problem solving. Felicia began to look in the mirror and actually see herself as too thin, a “waif” was the term she used. She was able to differentiate between a healthy Felicia and a nonhealthy Felicia. The NPP also recommended that she read the book Does This Pregnancy Make Me Look Fat? by Mysko and Amadei (2009), which addresses body image and promotes body confidence during pregnancy. The book also addresses ways to find one’s voice and deal with unwanted comments from friends, family, and coworkers.

Felicia’s third trimester was uneventful. She felt well and week-to-week became more excited about the baby. Her husband was supportive throughout the pregnancy. She was concerned about the baby’s progress and weight gain throughout, and did her kick counting each day. The baby’s weight progressed as well with normal fundal height measurements throughout the pregnancy; there was never a cause for alarm. At each prenatal visit Felicia and her husband were assured that the baby was doing well.

Postpartum

The birth of the baby does not mean that the new mother is free of the complications of her eating disorder. The postpartum period is when she must face her new body, which is not going to be the body that she remembers. The postpartum period is trickier than the prenatal period because the new mother may not be watched as closely as when she was pregnant. If the woman is breastfeeding, it is especially important that she does not revert to her disordered eating behaviors during attempts to lose her pregnancy weight.

The new mother should remember that losing weight after pregnancy takes time, and she should not have unrealistic expectations for herself. Tabloid and celebrity magazines unfortunately promote impracticable expectations regarding the length of time needed to lose weight in the postpartum period. New mothers, especially those with an eating disorder who are unsuccessful at achieving these unworkable goals, may become frustrated with themselves and depressed. Women who have an eating disorder while pregnant appear to be at a greater risk for a cesarean birth as well as postpartum depression (Franko et al., 2001; Gura, 2007). In a study conducted by Franko et al. (2001), 6.1% of the newborns in their group, whose mothers were experiencing an eating disorder at the time of their pregnancy, had reported a birth defect. This rate is higher than the number of the general population rate of 2.5% of first infants and 2.1% of second infants (Lie, Wilcox, & Skjaerven, 1994). An important finding in this particular study was the increased incidence of postpartum depression in a woman with an eating disorder. The general population rate of postpartum depression is approximately 13% (Agency for Healthcare Research and Quality, 2005; Clemmens, Driscoll, & Beck, 2004). According to their study, the group of women with an eating disorder reported postpartum depression at a rate of 34.7% (Franko et al., 2001).

Various studies have revealed that most women with a history of an eating disorder either prior to or during pregnancy return to their harmful eating behavior within months of birth (Mazzeo et al., 2006; Patching & Lawyer, 2009; Patel et al., 2005). Studies have shown that after 10 years or more of follow-up, persistent anorexia nervosa was noted in approximately 11% to 17% of the participants (Sullivan, Bulik, Fear, & Pickering, 1998). Even if the woman has re-established a normal healthy weight for her body type, these women still present with pathological obsessions and preoccupation with food and weight for years after being treated (Mitchell-Giegheim et al., 2002).

Nurses can discuss these issues with their patients before and during the postpartum period to prepare them for their emotions. The nurse should also help the woman develop effective coping mechanisms so that she will not
Warning signs of an eating disorder in pregnancy include no weight gain for two consecutive visits, hyperemesis gravidarium beyond 20-week gestation, and signs of depression or dieting during the pregnancy.

How to Identify an Eating Disorder

Although eating disorders are prevalent in the female population, there is scant literature regarding pregnancy or guidelines for assessment and treatment for the obstetrical patient. Healthcare professionals tend to consider eating disorders as more of a mental health concern than an obstetrical concern. There is also a connection between infertility and eating disorders, and many women suffering from this disorder either cannot reproduce or decide not to reproduce. According to Chizowsky and Newton (2007), eating disorders can be unique in their presentation because they include specific behavior disturbances.

A healthcare professional can diagnose an anorexic patient as one unrealistic about her weight and shape despite unusual thinness. The woman will appear very thin and have a troubling concern about weight gain. To obtain and maintain her extremely thin state involves unnatural and potentially dangerous methods of eating and weight loss, such as starvation, excessive exercise, food restrictions, and purgatives. A history of amenorrhea, infertility, recurrent miscarriage, or poor pregnancy results can be a red flag for an eating disorder.

There may be other physical signs, including dental problems, esophagitis, chronic sore throat, digestive issues, such as reflux or bowel problems, and general complaints of fatigue, backache, or leg cramps, which could be due to early signs of osteopenia or osteoporosis due to malnutrition. These women may also suffer from emotional symptoms, such as anxiety, low self-esteem, and altered body image. They may have a history of depression, bodily harm, or a suicide attempt (Steen, 2009).

Women with eating disorders, especially those who are trying to become pregnant or are pregnant, are typically reluctant or unwilling to share their disorder with others, especially healthcare providers. They are either embarrassed or ashamed to reveal their past or current illness, or they may be afraid that, while they are pregnant, their healthcare provider will pressure them to gain more weight than they would like.

Prenatal visits provide an excellent opportunity to assess for eating disorders and to guide women through their body weight and image worries. Nurses can use the information in Table 1 to assess women for eating disorders.

During these appointments, the nurse can support the woman and provide guidance to enhance the outcomes for her and her baby. The healthcare provider can elicit information by obtaining a thorough health and nutrition history, including determining presence of an eating disorder by asking about her reproductive history. An assessment of past menstrual cycles or a history of amenorrhea can alert the nurse to signs and symptoms of an eating disorder. The nurse can ask specific questions about periods of food restriction or low weight at certain times in the patient’s life, observe patterns of weight gain during the prenatal visits, and note stress levels while weighing the patient or discussing weight gain.

Warning signs of an eating disorder in pregnancy include no weight gain for two consecutive visits, hyperemesis gravidarium beyond the normal 20-week gestation period, and signs of depression or dieting during the pregnancy. If the nurse suspects an eating disorder, ask direct questions, such as “Have you ever been diagnosed with an eating disorder?” If the woman replies affirmatively, the nurse may inquire...
whether she was treated and what was the treatment modality. The nurse can also ask questions about nutrition during pregnancy and the woman’s relationship with food to determine a possible eating disorder. The SCOFF questionnaire (Table 2) is a useful assessment instrument. In addition, other assessment questions include

1. How do you feel about your body size now and the changes that are happening to your body?
2. Does your weight affect the way you think about yourself?
3. How do you feel about gaining weight during pregnancy?
4. What is it like for you to get on the scale here at each visit?
5. Have you had issues with food and your weight in the past?
6. Does being around food make you feel stressed and overwhelmed?
7. Do you ever feel at ease with yourself?
8. What is your stress level now?

Clinical Implications
At the time of this case study, there were no specific evidence-based guidelines for nursing care of an obstetrical patient with a current or past history of an eating disorder. Even so, suggestions for nursing care of these patients can be made (Chizawsky & Newton, 2007). Regardless of their weight issues, the illness goes much deeper on a psychological level, which may lead to denial and may be unrecognized during pregnancy. Even if the woman is aware of her illness, she might conceal the disorder due to embarrassment and the signs and symptoms are not always obvious. Consequently, careful and thorough assessments are crucial.

The nurse can offer education to the pregnant woman with a current or past history of an eating disorder with facts about body changes during pregnancy and realistic expectations regarding what will occur during the postpartum period. It is important to make the pregnancy “real” early on (Martos-Ordonez, 2005). To do this, have the patient pay close attention to the baby’s heartbeat, provide details on the normal development of the heart, and offer photographs of the growing fetus and information on the fetus’s growth and development at each stage of the pregnancy. Using photos and models of normal fetal growth and development may encourage the expectant mother to be more concerned about the baby, therefore establishing better eating habits. Continuous positive reinforcement concerning her diet and weight gain can further encourage her to eat healthy, gain weight, and accept her pregnant body (Chizawsky & Newton, 2007).

A multidisciplinary and collaborative approach is critical when treating a woman with an eating disorder in pregnancy (James, 2001). She may need a therapist who can provide supportive individual psychotherapy, a nutritionist experienced with eating disorders, and lactation consultant if she plans to breastfeed. In addition, planning for the postpartum period is critical to restore her balance and control during the transition to motherhood.

Another issue or concern for expectant mothers is the intrusiveness of friends, family, and even strangers regarding a woman’s pregnancy. Questions, especially about weight and body changes, can send an eating disordered woman into despair. The nurse should encourage the woman to set limits and boundaries to probing questions, reinforcing the fact that she does not need to discuss her weight or body size with anyone. She can simply respond that she does not know how much weight she has gained, or that she is not comfortable discussing her weight. When others make jokes about her weight, simply telling them that they are hurting her feelings will make them stop.

A support group may help to alleviate anxiety and expand the focus to help the patient consider not only body shape and weight but also support the adjustment to her new identity as a mother. These women need to discover their self-worth and focus on their new maternal role, rather than focusing only on their bodies and diets. Individual psychotherapy support is crucial as well because eating disorders are usually symptomatic of deeper underlying issues. Yoga can be an effective method in the treatment of eating disorders (Douglass, 2009). Yoga may help the woman develop an awareness of her body as more of a living and breathing being as opposed to a separate entity that she dislikes and attempts to manipulate. A prenatal yoga class may be beneficial, pending approval of her healthcare provider.

Supporting the Anorexic or Bulimic Expectant Mother
Nurses can help to provide guidance for healthy eating. A referral to a mental health provider and support group is essential. An appointment with a nutritionist who specializes in eating disorders can help the woman gain a healthy perspective on eating, prevent a relapse during pregnancy and during the postpartum period, help her

Table 2. The SCOFF Questionnaire

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes/No</th>
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<tr>
<td>Do you make yourself sick because you feel uncomfortable full?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Do you worry you have lost control over how much you eat?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Have you recently lost more than one stone (14 lb) in a 3-month period?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Do you believe yourself to be fat when others say you are too thin?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Would you say that food dominates your life?</td>
<td>Yes/No</td>
</tr>
</tbody>
</table>

Score one point for every “yes”; a score of 2 indicates a likely case of anorexia nervosa or bulimia.

Source: Morgan, Reid, and Lacey (2000), Pritts and Susman (2003), used with permission.

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focus on more positive thoughts surrounding food and weight gain, and help her recognize triggers or signs of relapse into old negative habits.

Case Study, continued…… Having the support of a therapist, a nutritionist, and an understanding obstetrical healthcare provider, Felicia came to terms with her depression and symptomatology early enough that we were able to “nip it in the bud.”

The Edinburgh Postpartum Depression Screening Scale with a score of 21 diagnosed her depression. They immediately worked on the depressive symptoms related to her weight, and worked on her diet with her nutritionist. With the help of a lactation support group, she was able to come to terms with her body image and pregnancy weight. She restored her self-esteem and realized that her eating disorder simply did not fit into her life as a new mother with a new family. She eventually appreciated the fact that she was a good mother, a valuable wife, and an attractive woman, no matter what she weighed.

Conclusion

Adjusting to pregnancy and motherhood can be overwhelming. New mothers need to assimilate into their role, which emphasizes values involving caring and nurturing. With the recent literature on the negative effects of an eating disorder in pregnancy, there is an urgent need for nurses to be aware of the signs and symptoms of an eating disorder in the pregnant woman. Denial of the disorder makes it that much harder for nurses to form an eating disorder simply did not fit into her life as a new mother with a new family. She eventually appreciated the fact that she was a good mother, a valuable wife, and an attractive woman, no matter what she weighed.

The nurse should encourage the woman to set limits and boundaries to probing questions from friends and family. Reinforcing that she does not need to discuss her weight or body size with anyone. She can simply respond that she does not know how much weight she has gained, or that she is not comfortable discussing her weight.

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The author declares no conflict of interest.


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The National Eating Disorders Association www.nationaleatingdisorders.org

The Anorexia Bulimia Association www.aabainc.org

Anorexia Nervosa and Related Eating Disorders www.anred.pm/

Something Fishy Organization www.something-fishy.org/

Love Your Body http://loveyourbody.missouri.edu/signs.htm

Helpguide www.helpguide.org/mental/eating_disorder_self_help.htm

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Published in MCN September/October, 2011, vol 36, no 5

Ms. Hung is Perinatal nurse at the Birth Center, San Francisco General Hospital and Trauma Center, San Francisco, California, where Ms. Berg is a Perinatal clinical specialist.

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“Impact of a Formal Breastfeeding Program”.

Published in MCN March/April 2011 vol 36 no 2

Ms. Mellin is a Perinatal clinical specialist at Morristown Memorial Hospital, Morristown, New Jersey, where Ms. Poplawski is the manager of the maternity center, and Ms. Gole is the manager of parent education. Dr. Mass is an obstetrician with Morristown Obstetrics and Gynecology Associates in Morristown.