

The Experience of Pregnancy for Women With a History of Anorexia or Bulimia Nervosa

L'expérience d'une grossesse pour les femmes ayant un antécédent d'anorexie mentale ou de boulimie

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ABSTRACT

Using descriptive phenomenology, we explored the experiences of women who have an eating disorder prior to, or during pregnancy. Eating disorders often go untreated during pregnancy despite an association with miscarriage, low infant birth weight, hypertension, and postpartum depression. A purposive sample of ten Caucasian women aged 18 or older, who self-reported a history of an eating disorder during a pregnancy, was interviewed. Essential textual phrases were highlighted based on van Manen's approach to thematic analysis. Most women use eating as a means to cope with a distorted body image which was established early in their lives and continued to some extent during and after pregnancy.

Five themes, emerged from the text which describe the phenomenon of eating disordered behavior: 1) a constant mental struggle to prevent loss of control, 2) a distorted body image, 3) scale-induced trauma, 4) hiding the lived experience, and 5) postpartum fear and panic. By understanding the subjective experience, healthcare providers may be able to provide more sensitive care to women with eating disorder behaviors.

KEY WORDS

pregnancy, body image, eating disorders, anorexia nervosa, bulimia nervosa, personal knowing, weight gain

RÉSUMÉ

En nous servant de la phénoménologie descriptive, nous avons exploré les expériences de femmes ayant des troubles de comportement alimentaire avant ou durant une grossesse. Souvent les troubles de comportement alimentaire ne sont pas traités lors de la grossesse malgré un lien avec les fausses couches, l'insuffisance pondérale à la naissance, l'hypertension et la dépression postpartum. Un échantillon intentionnel de dix femmes blanches âgées de 18 ans ou plus qui avaient elles-mêmes rapporté un antécédent de troubles de comportement alimentaire lors de la grossesse furent interviewées. Des locutions textuelles essentielles furent mises en évidence utilisant l'approche d'analyse thématique de van Manen. La majorité des femmes utilisent la nourriture comme un moyen pour gérer une image corporelle déformée qui fut établie tôt dans leur vie et qui perdure jusqu'à un certain point pendant et après la grossesse.

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Cinq thèmes décrivant le phénomène des troubles de comportement alimentaire ont émergé du texte : 1) un combat psychologique constant pour éviter la perte de contrôle, 2) une distorsion de l'image corporelle, 3) un traumatisme provoqué par la mesure du poids, 4) cacher l'expérience vécue, et 5) peur et panique postpartum. En ayant une meilleure compréhension de l'expérience subjective, les prestataires de soins de santé pourront être en mesure de fournir des soins plus appropriés aux femmes ayant des troubles de comportement alimentaire.

MOTS CLÉS

grossesse, image corporelle, troubles de comportement alimentaire, anorexie mentale, boulimie, connaissance personnelle, prise de poids

In a review of the literature, the mean prevalence of anorexia nervosa in young females was estimated to be 0.03%.¹ One to five percent of high school girls have bulimia nervosa, increasing to 19% among college women surveyed.² Although these statistics point to potential problems for women of childbearing age, the prevalence of eating disorders in pregnant women has rarely been investigated. The incidence of these disorders in pregnancy is unknown but a study of 421 women in a London antepartum clinic reported that 8% of women may experience symptoms of eating disorder behaviour during pregnancy, and possibly 1% of women may have an active eating disorder during late gestation.³ This is likely an underestimation because these disorders are often unrecognized and go untreated during pregnancy due to inadequate screening and diagnosis by health care providers.⁴

Table 1 defines anorexia and bulimia nervosa, according to the Fourth edition of the Diagnostic and Statistical Manual of Mental Disorders.⁵ Although there are differences between anorexia and bulimia, these disorders can coexist. Thirty-five percent of women with anorexia nervosa develop bulimia nervosa, and 27% of women with bulimia nervosa develop anorexia nervosa at some point throughout their illness.⁶ The purpose of this phenomenological study is to describe the lived experience of having an eating disorder prior to, or during pregnancy.

Literature Review

The effect of an eating disorder on the pregnant woman and her fetus can be severe and significant, especially when it is not detected.⁷ A literature

search on eating disorders in pregnancy produced conflicting findings. Several quantitative research teams report serious maternal or newborn complications,⁸⁻¹¹ while other researchers report a lack of medical complications and normal infant birth weights.¹²⁻¹⁴

Abraham et al.⁸ discovered an increased risk of hypertension, intrauterine growth restriction, gestational diabetes, pyelonephritis, and vaginal bleeding among a subset of 100 healthy women who were studied three days after the birth of their first child. Of this group, women reporting disordered eating were more likely to have antenatal complications and give birth to low birthweight babies. Using a case series design, Stewart explored five-minute Apgar scores and infant birth weights of babies from 74 women previously treated for anorexia nervosa or bulimia.¹¹ Fifteen women who still had active episodes of anorexia or bulimia had 23 babies with lower Apgar scores and lower birth weight. Mitchell et al.¹⁰ compared the outcome of 38 pregnancies in 20 women with active bulimia to 50 pregnancies in 31 women who had no history of eating disorders. Their results, while not statistically significant, indicate that the risk of miscarriage is approximately twice as high in women with bulimia. Franko et al.¹² described the course of pregnancy for 49 women with a history of anorexia or bulimia. Of the 49 women, 22 had an active eating disorder when entering their pregnancy, and 25 were not symptomatic at the time of conception (two of the participants had missing symptom data). The sample was divided into two groups and compared to assess differences in eating disorder symptoms during pregnancy. There were no statistical

Table 1: *Eating Disorder Definitions*

Anorexia Nervosa	A refusal to maintain body weight at or above a minimally normal weight for age and height, resulting in a body weight 15% below normal, and the absence of at least three consecutive menstrual cycles.
Bulimia Nervosa	Recurrent episodes of binge eating and inappropriate compensatory behaviour in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.

differences between the two groups in Apgar scores, birth weights or gestational age at delivery, suggesting that the majority of women with bulimia and/or anorexia have normal pregnancies and healthy babies. Similarly, two other researchers reported adequate maternal weight gain, average birth weights, and no increased incidence of congenital abnormalities among women with eating disorders.^{13,14}

Numerous authors claim improved eating habits during pregnancy in women previously diagnosed with an eating disorder, demonstrating that pregnancy can, in fact, be therapeutic for affected women.¹³⁻¹⁷ Blais et al.¹⁵ conducted a prospective, comparison study of 54 women with either anorexia or bulimia during pregnancy. Women in both the anorexic and the bulimic groups improved during pregnancy, reporting less restrictive behaviour or less bingeing and purging. Crow et al.¹⁶ also examined change in symptoms during pregnancy in 129 women with bulimia and found reduced binge eating and purging during pregnancy. Fifty-seven percent of women reported the frequency of binge eating to be diminished during pregnancy while 7.4% reported an increase, and 33.0% were unchanged ($p < .001$). There were similar findings for purging. It improved for 64.5%, worsened for only 7.5%, and remained the same for 28.0% of women ($p < .001$). In a recent study by Rocco et al.,¹⁷ 150 women with anorexia or bulimia were surveyed prospectively to investigate the effects of pregnancy on eating disorders. There was an improvement of symptoms during the mid-trimester. A consistent finding in each of these studies, however, was a return or

worsening of eating disorder symptoms in the postpartum period.

Missing from the literature is a description of women's experiences of having an eating disorder during pregnancy. Consequently, this phenomenological study employed in-depth, open-ended questioning in order to gain insight about women's lived experiences. Phenomenology was used for the study in order to seek a better understanding of the meaning and significance of the lived experience of women with eating disorders during pregnancy. As a seldom self-reported phenomenon, it was important to discover its essence through the textual expression of individual participant interviews.¹⁸ The objective of the study is to enable women with a history of anorexia or bulimia to share their experience of pregnancy.

Methods

Recruitment flyers were posted in obstetric clinics at two major medical centres in California. The study was reviewed and approved by Institutional Review Boards at the affiliate university and at two medical centre used as the primary recruitment sites. Informed consent was obtained before interviews were conducted.

Seventy-five obstetricians and midwives were informed about the study and were asked to refer women who met the inclusion criteria. The inclusion criteria were: 18 years of age or older, currently pregnant or had at least one child, and self-report of a history of anorexia or bulimia, a physician's diagnosis of anorexia or bulimia prior to, or during at

least one pregnancy. A recruitment announcement was posted on the Anorexia Nervosa and Related Eating Disorders (ANRED) website. Ten participants were purposively recruited from two large teaching hospitals in a major city in California. A participant's self report of anorexia or bulimia, as defined in the 4th Text Revision of the Diagnostic and Statistical Manual of Mental Disorders⁵ was necessary for inclusion. All participants reported having been diagnosed with an eating disorder by a physician and receiving some type of treatment or professional counselling in the past.

Demographic information and a brief eating disorder history were obtained from each participant and are presented in Table 2. Fictitious names were given to each participant to preserve their privacy. The interview included open-ended questions about women's body image and eating habits across their lifespan; the impact of pregnancy on eating habits, the experience of obstetrical visits during pregnancy, and seeking help for an eating disorder during pregnancy (Table 3). The interview guide kept the researcher focussed on the phenomenon of interest, yet encouraged free-flowing conversation.¹⁹ Participants were

interviewed one time, and each interview was one hour in length. Interviews were audio taped and transcribed verbatim as the data for analysis. Meaningful phrases were highlighted by each researcher. A coding scheme was created that emphasized listening and discovery while bracketing predetermined concepts. Narrative segments and phrases were coded using the qualitative research program NVivo.²⁰ Data was managed by indexing passages of text, labelling, coding and categorizing (or grouping) text, then retrieving and sorting coded passages across all ten interviews.

A nurse researcher, employed at one of the recruitment sites, who was not directly involved in the study, verified the research audit trail and contributed additional interpretive statements after reviewing exemplary passages of text, the coding scheme, and emergent themes. Member checking²¹ was used with three of the study participants who validated the five thematic descriptions. Sufficient time to collect and analyze data over five months of interviews contributed to the depth and richness of the themes. It was possible to reflect first upon the data from the initial interviews and continue a

Table 2: Demographic Characteristics of Informants (mean age-32, mean eating disorder duration-14 yrs)

Code Name	Age	Number of Pregnancies	Number of Children	Pregnant during Interview	Occupation	Eating Disorder	Eating Disorder Duration
Stacy	33	1	0	Yes	Nurse	Bulimia	12 yrs
Mary	27	6	1	Yes	Homemaker	Anorexia	14 yrs
Nancy	32	3	3	No	Homemaker	Anorexia/ Bulimia	16 yrs
Joan	31	3	4	No	Homemaker	Anorexia/ Bulimia	13 yrs
Rachel	26	1	0	Yes	Teacher	Bulimia	7 yrs
Sharon	33	1	0	Yes	Homemaker	Anorexia/ Bulimia	20 yrs
Elizabeth	35	3	3	No	Nurse	Bulimia	8 yrs
Kate	31	2	2	No	Homemaker	Bulimia	15 yrs
Lori	36	1	0	Yes	Principal	Anorexia	8 yrs
Crystal	39	1	0	Yes	Nurse	Anorexia/ Bulimia	27 yrs

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Table 3: *Focused Open-ended Interview Guide*

Can you think of some personal reflections or experiences that describe what your eating and exercise patterns are like?
Did pregnancy alter your eating patterns?
What images come to mind when you think about your body? Have those images changed at different times in your life?
Have your eating behaviours changed over time?
Who do you talk to about your eating habits and why?
Tell me what it is like for you when you go to your doctors office for a prenatal visit?
Do you confide or conceal your eating disorder history from anyone?

prolonged engagement with all of the textual data over time. The emersion "over time" contributed to the unique characterization of the phenomenon. Engaging the women in a discussion that spanned early childhood, adolescence, early adulthood, and pregnancy added completeness to the analysis.

Results

Five major themes emerged that describe the experience of pregnancy for these ten women: 1) a constant mental battle to prevent losing control, 2) a distorted body image, 3) hiding their experience, 4) scale-induced trauma at prenatal visits, 5) postpartum panic and fear. Each of the five themes is presented below with supporting verbatim excerpts from study participants that capture the essence of their experience.

A Constant Mental Battle to Prevent Losing Control

Entering a pregnancy with a history of an eating disorder created internal conflict. Although nine of the women considered themselves to be in remission from their eating disorder during their current or most recent pregnancy, many admitted struggling with accepting weight gain and the increased body size that accompanied their pregnancy. Adjusting to the body changes of pregnancy was described as a "mental battle" and was perceived as a constant struggle between acceptance of the pregnancy and a fear of losing control over their changing bodies. Study

participants were most likely to engage in an eating disorder when they sensed a loss of personal control in their lives.

I was totally a freak about my diet and about fat intake and about exercising before I got pregnant, and it continued somewhat during my pregnancies, but again, I had to let myself gain weight. I struggled, you know, dealing with the weight gain, kind of between not liking it and being uncomfortable with it but also knowing that it needed to happen to have healthy babies, so it was kind of a constant struggle (Elizabeth).

Elizabeth had a history of bulimia and expressed fear and a sense of losing control when asked to describe what it was like to gain weight in pregnancy:

Control was a big thing because I felt like I could always control my weight, and I guess I lost that control in a way because I did gain weight, which was the very opposite of what I wanted to be doing for several years before I got pregnant. It was scary to be out of control of my body and my weight, but I did want to have a healthy baby, and so I tried very hard to at least gain weight (Elizabeth).

A Distorted Body Image

When asked to define the term body image, all ten of these women said it was the way they perceived everything about their bodies. For all of them, this term included their personal perception of their self-worth as an individual.

What body image means is how you feel about yourself when you look at your body in the mirror, how does that make you feel about your whole self... your self-worth or something. You know, whether you're good or bad, or attractive or not. It's really a superficial thing, but it affects your whole sense of worth as a woman (Kate).

Having a distorted body image was a recurrent concern among all the women interviewed. As their bodies became more visibly pregnant, several of the women spoke of the difficulty of looking at themselves in a mirror.

When I look in the mirror and I see that my butt has gotten bigger, or that I have cellulite for the first time again since I was seventeen, and my butt and thighs... those are my bad days (Rachel).

Family psycho-dynamics surround early recollections of body image disturbance that resurface later in life in their relationships with others. Two women recalled mothers and sisters who were constantly on diets. Three of the women had a sister, a boyfriend, or an aunt with an eating disorder. Several women stated that feelings of low-self esteem and a negative body image were the result of parental lack of approval. Other participants described husbands who commented on weight gain and suggested exercising to keep it under control.

To compensate for low self-esteem, some participants practiced habits such as restrictive eating, compulsive exercise, laxative use, or bingeing and purging in an effort to control their weight as a way to regain self worth.

I couldn't go anywhere without my laxatives. And the worst part about it was that I always had to be near a bathroom because I never knew when my body was going to get rid of everything I had eaten. (Rachel)

When these women became pregnant, habits were very difficult to stop but impossible to ignore because of health concerns about their baby.

Hiding their Experience

Women with anorexia often hide the fact that they are not eating. One woman gave an example of telling her husband, in-laws and friends that she had already eaten, in order to hide her desire not to eat to prevent weight gain in her pregnancy. Another woman tried to hide the fact that she exercised excessively during her pregnancy.

I kinda lie when people ask and I say I do thirty minutes when I actually do an hour and a half on the treadmill everyday. (Mary)

Similarly, women with bulimia try to hide their behaviour. It was possible for these women to hide because their eating disorder behaviours were

undetected or denied for years even by immediate family members.

Hiding the behaviour in pregnancy was simply a natural extension of a long trajectory of hiding their symptoms in the past. Only three of the ten participants voluntarily reported their history of an eating disorder to their physician or midwife. None of the ten women recalled being asked whether they had a history of an eating disorder. At times, some women hid their bulimic behaviour by rationalizing it to themselves and to others as being nausea associated with pregnancy or the flu.

I never shared it with my husband. He thought I'd completely stopped purging. I pretty much had stopped it, but there were times I would indulge in a craving knowing that I could get away with throwing up by just saying that I was nauseous and it just came up. The possibility of hurting the baby was one of those two-second fears, and then it was like immediately something would talk to me saying, "Do you know how many women throw up 30 times a day and still have healthy babies? What are you thinking? Just do it... once isn't going to hurt the baby. (Sharon)

One woman, recovering from anorexia and bulimia, disclosed her eating disorder history to her physician, but immediately afterward wished she had not. To her, the physician did not seem to be worried about her history, because she was currently at a healthy weight for her stage of pregnancy. She felt that this lack of attention to the disclosure of her illness actually contributed to her occasional relapses of eating disorder behaviour during her pregnancy.

Scale-Induced Trauma

Nine of the women interviewed were routinely weighed at their prenatal care appointments. Eight of them described this experience as the most traumatic event associated with pregnancy. Medical assistants or aides weighed the women as soon as they arrived for their visit, and no explanation was given for the rationale behind why this was being done. For most of the women, their weight or weight gain was never addressed during the prenatal visit with the physician or midwife. Recollections of being weighed elicited profound emotional

responses. One woman, recovering from anorexia during her pregnancy, shed tears when asked to describe this experience.

It was always a trauma. It's very hard. I wish you weren't facing the scale and they didn't let you see your weight. I was stressed every time I had to go to the doctor and be weighed to see how much I'd gained because I was very, very rigid so that I wouldn't gain what I thought was too much weight. I even wore the same clothes to the doctor's visits so that I would know exactly how much was weight and how much was clothes. (Joan)

Fear and anxiety were common emotions expressed by eight of the ten women when asked about weight gain and the experience of having to stand on the scale. One woman struggled with bulimia during each of her three pregnancies and worried that her doctor was going to think she was fat or that she was a "bad person". For her, having to be weighed was described as "the worst thing about pregnancy."

I dreaded getting on the scale. I was terrified. I mean, I had no idea what to expect. I had read everything I could get my hands on and so I knew what the average was, but I was really scared that I would just gain gobs and gobs and gobs of weight and be very overweight again. So every time I went and got weighed, you know, depending on what the scale said, it was either good or bad. (Elizabeth)

Postpartum Panic and Fear

All ten of the participants expressed concern, fear, worry, or panic when asked how they felt about their bodies after they delivered their baby. The postpartum period was described as "the hardest part about having a baby." There was extreme worry postpartum with being overweight and with what other people would think about them. Body image was a preoccupation during this time, and the women described feelings of "fatness", "being stressed", or being encouraged to exercise by their husbands. Three women reported a return or worsening of their eating disorder symptoms after childbirth. None of the women reported a history of postpartum depression.

I think the harder part is after you've had the baby and coming to terms with that new body, you know, when

you still look like you're pregnant. I probably had more incidences of bingeing and purging right after the baby was born because of the lack of sleep and also the feeling that, well, the baby's not inside of me anymore, you know, I'm not really hurting the baby if I binge and purge. (Kate)

Discussion and Implications for Providers: Constant Mental Battle and Loss of Control

Whether they are restricting intake or bingeing and purging, the ten women in this study were trying to control what they believe were unacceptable feelings inside themselves and imposed from the outside world. For these participants, gaining weight in pregnancy is synonymous with "losing the mental battle". The mental battle was struggling with the intellectual understanding that weight gain was necessary for the health and growth of the baby versus the need to restrict weight gain in order to control their distorted body image. Women in this study used their eating disorder rituals and obsessions of weight control in an attempt to regain personal control and emotional coping when anger, anxiety, sadness, disappointment, disapproval, fear of rejection, or loneliness arose in everyday life.

Pregnancy is a time marked by unpredictability, which can be challenging even for healthy women. The women in this study reported antecedent factors similar to findings reported in the literature.¹⁰ Perfectionism, obsessiveness, and negative self-perception are observable in women with eating disorders. Women with eating disorders place a high value on control and predictability in life, and thus can become highly vulnerable to self-induced control during this period.¹⁰

A Distorted Body Image

Physical changes of pregnancy cause many women to reevaluate their bodies and their sexual identity. While the physical changes of pregnancy embarrass and inhibit some women, they are a source of awe and joy for others.²² It was not surprising to the researchers that these ten women struggled with body image in pregnancy, because a distorted body image is a known characteristic of women suffering from anorexia and bulimia.²³

In one retrospective survey of 20 pregnant women

with a history of bulimia, 25% were disturbed by their change in body size and shape and reported feeling "ugly, huge, and sexually unattractive", while 75% did not report this same problem with body image. Thirty percent actually described feeling "proud and pleased" with their change in shape.⁹ Lemberg and Phillips¹³ surveyed 43 women who identified themselves as having an eating disorder prior to their first pregnancy. The majority of respondents did not equate pregnancy with feeling fat or unattractive. However, the pregnancy did not appear to foster self-acceptance of body image, and 80% of the women who reported a return of symptoms after childbirth attributed their relapse to "feeling fat and wanting to lose weight". In a larger, descriptive study, 113 women with bulimia described their body changes as positive during pregnancy, but quickly lost tolerance for the changes after childbirth.²⁴

Routine Evaluation of Weight Gain

Women with eating disorders know that weight gain is necessary in pregnancy, but observing the uncontrollable changes in their body size and shape brings significant emotional and mental challenges.⁷ The frequent weigh-ins, discussions about weight gain, and even well-meaning remarks by clinical staff can be triggers for increasing the frequency of eating-disordered habits. In this study, weighing in was a highly stressful event. These findings are consistent with previous research.²⁵

In a triangulated, mixed-method study, 150 pregnant women and 27 midwives and physicians at an Australian clinic were surveyed to identify the impact of ceasing this tradition. Study results indicated that the practice of weighing during a routine prenatal visit was not important for all but four pregnant women.²⁶ Eighty-eight percent of the midwives strongly supported abandoning the practice of weighing. They believed that routine weighing caused increased maternal anxiety and worry. Their comments included, "you spend time reassuring women and their anxieties about their weight gain or loss...when you could be instead routinely taking the time to educate them on their diet" (p. 29). Similarly, 90% of the physicians did not support the standard practice of weighing every pregnant woman and believed that the pattern of

weight gain had little importance in pregnancy.²⁶

There is a lack of research evidence to support routine antenatal weighing among women who have a normal pregnancy. Healthcare providers must be sensitive to the anxiety that routine weight monitoring may impose on some women. Instead of routine weighing being an unconscious activity by medical office staff, they can ask in a caring manner, "What is it like for you to be weighed during pregnancy?" or "What is it like for you to be weighed at every visit?" These questions may open the door for a more comprehensive discussion about weight issues during pregnancy.²⁵ Anxiety over weight gain in pregnancy could be detected by a simple question and raise a signal for needed education about nutritional requirements of the fetus as a rationale for weight gain.

These women suggested that they be given the opportunity to weigh in the privacy of their own home and report their weight to their provider. Another suggestion was not having their weight reported to them. Consistent with published studies,^{13-15,24} these women also described a return to, or worsening of eating disorder behaviour after childbirth to control their weight and body image. Their simple suggestions about the practice of weighing may be important to consider even after pregnancy.

Hiding the Behaviour

A significant finding from this study is that the participants were unlikely to disclose their eating disorder history during pregnancy. Hill²⁷ reported that women with an eating disorder in pregnancy might perceive a social stigma attached to seeking help. Feelings of shame and guilt associated with the behaviour may make a woman reluctant to disclose. Some patients deny a disorder exists.⁴ Furthermore, health providers do not ask patients about eating disorder histories. In a convenience sample of 67 obstetricians, Abraham²⁸ found that many physicians asked women about cigarette smoking and alcohol intake before pregnancy, but fewer than 50% asked about depression, body weight control, or a history of an eating disorder. Nearly one-third of the physicians could not recall seeing a woman with an eating disorder in the prior year.²⁸

Creating an environment at prenatal visits that is sensitive to and understanding of the needs of each individual woman may indirectly encourage disclosure of an eating disorder.²⁹ Certain questions may help differentiate pregnant women with anorexia or bulimia from pregnant women with normal body dissatisfaction. Inquiry about 1) body weight (usual, highest, recent changes), 2) current and anticipated perceptions of body size and shape, 3) desired weight gain during pregnancy, and 4) current weight control tactics, meal and snack patterns, and physical activity may be helpful in assessing whether a pregnant woman is bulimic or anorexic.³⁰

Recognizing individuals at risk for eating disorders is a vital first step in beginning treatment and addressing the ultimate goal of reducing incidence.⁷ Two screening measures for eating disorders may be helpful to assess and diagnose eating disorders. One measure is the self-reported Eating Disorders Examination Questionnaire³⁰ and the other is the five question SCOFF Questionnaire.³¹

Limitations

The data is based on a small sample size of Caucasian, married women who self-reported having an eating disorder during pregnancy. Some participants reported some degree of recovery from their eating disorder at the time of the interview, which could be considered a limitation of the study. A sample that includes only women who are currently pregnant and experiencing an active eating disorder might have produced different results. It is difficult, however, to recruit women who are currently pregnant and experiencing an active eating disorder. Therefore, women who had an eating disorder in a current or a previous pregnancy were included in the sample. These ten women were selected because they were able to acknowledge and discuss the impact of their eating disorder on their pregnancy. While our study allows important insight into the lives of eating disordered women and the way they experience pregnancy, it is impossible to generalize these findings to the larger population of women.

Conclusions

Our research team identified themes which

described ten women's experiences of having anorexia or bulimia prior to, or during pregnancy. While these themes cannot be generalized to all women with eating disorders, they are supported by earlier concepts identified in the literature. A finding from this study that extends the literature is the notion that women who have an eating disorder can slide in and out of remission and active disease. By understanding the nature of women's experiences of having an eating disorder prior to, during, and after pregnancy, healthcare providers can exercise greater sensitivity and awareness. In order to do this, health care providers must be aware of the prevalence and secrecy of eating disorders.

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