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UNIVERSITY OF ALBERTA

# EATING DISORDERS DURING PREGNANCY

BY

BECKY CAROLYNN HILL 

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of MASTER OF NURSING.

FACULTY OF NURSING

Edmonton, Alberta

Fall 1997

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Date

**You gain strength, courage, and confidence**

**by every experience in which you really**

**stop to look fear in the face....**

**You must do the thing you cannot do.**

**Eleanor Roosevelt**

## DEDICATION

To my family who never ceased to provide love, encouragement and support.

To my loving husband Bill for believing in me and supporting me in countless ways.

To all of the women who participated in this study and who are beginning to face the challenges ahead on their road to self love, acceptance, and healing.

**Abstract**

Eating disorders are a significant health concern for women today. The preoccupation with weight and eating among women has reached epidemic heights as evidenced by the increasing numbers of women experiencing eating disorders commonly known as anorexia nervosa and bulimia nervosa. Statistics on eating disorders are alarming: almost 95 % of anorexics and bulimics are women and the increased prevalence of these eating disorders among women of the childbearing years, combined with more effective treatments for these conditions, has resulted in a larger percentage of these women eventually becoming pregnant. The purpose of this study was to explore and describe the experience for women of having an eating disorder, namely anorexia nervosa and/or bulimia nervosa, during pregnancy. In this study, qualitative methods were used and a grounded theory analysis was employed. Ten women who had experienced an eating disorder during their pregnancy provided data during interviews conducted during or post pregnancy. Two additional participants were sampled to clarify and verify the developing categories.

For women in this study, the findings indicate that women manage their eating disorder during pregnancy through the social process of protecting: of self and of baby. The process of protecting exists along a continuum with protecting self-image--motivated by the pursuit of thinness--on one extreme and protecting the baby--motivated by the health of the baby--on the opposite extreme. A woman accomplishes this process by assessing risks to baby versus threat to self-image and by seeking reassurance. Depending on how this is perceived, a woman engages in protective behaviours that lean towards one or the other extremes. Where a woman exists on this continuum is also largely related to the six factors which influence the process of protecting: (1) fear, (2) uncertainty, (3) guilt, (4) body image, (5) motivation, and (6) support. An additional category of making the transition to parenthood was included to provide insight into the continuing complexities of the participants' world. The negotiation of nutritional status was also explored as a representation of a protective behaviour.

Information obtained as a result of this study provides midwives, nurses and other health care professionals with increased awareness and understanding of the experience for women of having an eating disorder during pregnancy. It is with this increased awareness and understanding from midwives, nurses and

other health care professionals that women may be more willing to disclose their eating disorders and thereby receive appropriate referral and health care pre and postnatally. If an optimal state of health can be achieved and maintained throughout pregnancy, neonatal morbidity and mortality may be decreased and prevented as well as improved maternal outcomes, both physiologically and psychologically. It is also hoped that through the achievement of a greater awareness and understanding of eating disorders in general, a social climate will emerge which supports and encourages women to accept themselves for who they are as unique and valued individuals.

**Acknowledgements**

I would like to express my deepest appreciation to the many individuals who supported and assisted me with this research. Many thanks to my thesis supervisor, Dr. Peggy-Anne Field, for her continued support with this research and her expertise regarding pregnancy and women's health. It is with her invaluable guidance that I have become as passionate about women's health and related issues as I presently am, and it has truly been a pleasure learning and growing as a result of having her a part of my life. I also want to extend my sincere thanks to my other committee members, Co-Supervisor Dr. Wendy Austin, Dr. Beverly O'Brien, and Dr. Barbara Paulson, who provided further expertise and guidance during this research.

I wish to acknowledge several of my collegues who were of great encouragement and support during this program, namely those special friends who share the passion of midwifery and women's health along with me. Together we stand united...with the promise of a brighter future! Thanks for being an endless source of strength and positive energy!

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The completion of any project is made much richer by the love, interest, and generosity of family and friends. Their pivotal presence reaffirms the importance of how change and growth, although difficult, are made easier by the relationships that unselfishly promote them. A very special thanks to my mother Rose Marie who has believed in me from the start and whose endless encouragement and support has made this, and so many other things in my life, possible. Your questions, constructively critical comments, and your belief in the importance of my research and academic pursuits sustained me in moments of doubt and fatigue. This one's for you! Thanks to my father Gordon for instilling in me the value of always giving your best, and settling for nothing less.

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Finally, I would like to acknowledge the Canadian Nurses Foundation for their financial support of this research study.

*"If you bring forth what is within you, what you bring forth will save you . If you do not bring forth what is within you, what you do not bring forth will destroy you."*

*Jesus*

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# CHAPTER I

## INTRODUCTION

*Diseases of the soul are more dangerous, and more numerous, than those of the body.*
*Cicero*

The phenomena of eating disorders, namely anorexia nervosa and bulimia nervosa, during pregnancy is one of significant societal and clinical importance. Pregnancy stresses not only the body but also the psyche. Many women intuitively know that their lives will change dramatically forever as they face the joys and challenges of prospective motherhood (Zerbe, 1993). This stress means that even under the most optimal and beneficent of conditions, most women will be dramatically impacted and will find themselves worrying about the outcome of their pregnancy: Will the baby be healthy? Will I be a good mother? For the woman with an eating disorder, the added psychological and physical stress of pregnancy, as well as the idea of becoming a mother, can be incapacitating as she struggles to put her own life into perspective. The issues that this childbearing event, a normal developmental life experience for many, brings forth in women with eating disorders are undoubtedly intense, overwhelming, and complex. In addition to the above questions, the women begin to ask themselves: How will my eating disorder affect my baby and my capacity to be a mother? The answers to these questions remains relatively unexplored.

The increased prevalence of eating disorders among women of the childbearing years, combined with more effective treatments for these conditions, has resulted in a larger percentage of these women eventually becoming pregnant (Burke, M. & Vangellow, J. 1990; Szmukler, 1985; Stewart, D., Raskin, J., Garfinkel, P., MacDonald, O., & Robinson, G., 1987). There is evidence that both anorexia nervosa and bulimia nervosa can also be precipitated by pregnancy (Weinfeld, R., Dubay, M., Burchell, R., Millerick, J. & Kennedy, A., 1977; Price, W., Giannini, A. & Loissell, R., 1986). Pregnancy is a time of many psychological shifts as the woman reflects on the responsibilities of motherhood. The psychological conflicts experienced may herald the development of an eating disorder (Zerbe, 1993).

Preoccupation with weight and eating among women is not restricted to a few women, nor does it include only women who are bulimic or anorexic. Dieting and weight control have become an accepted and rewarded way of life for women (White, 1992). Today, women who are not concerned about their weight are a social anomaly. Anorexia nervosa, or self starvation, and bulimia, or binging and purging, are the extremes on a continuum of weight preoccupation among women in Western societies (Brown, 1993; Butler, 1988). The rest of the female population also seems to exist on this continuum of weight preoccupation, even if not on the extreme ends. Eating disorders are undoubtably a female malady, one which is becoming increasingly more destructive as evidenced by the ever increasing morbidity and mortality rate of women suffering from them (Wolf, 1991; Seid, 1989; Orbach, 1982).

The statistics on eating disorders are alarming: almost 95% of anorexics and bulimics are women (Canadian Association of Anorexia Nervosa and Associated Disorders, 1997; Bemis, 1987; Striegel-Moore, Silberstein, and Rodin, 1986). According to the published figures, two of ten women will be anorexic, six of those ten will be bulimic, and only two will be well (Brumberg, 1988; Chernin, 1986; Seid, 1989; Thomas, 1995). The norm, then, for North American women is to suffer from some form of eating disorder (Wolf, 1991). A recent and accurate prevalence rate of eating disorders during pregnancy is unknown, the estimates vary considerably, but it has been suggested that bulimia nervosa may occur in approximately 1.3 % - 19 % of pregnant women in the United States (Schotte & Stunkard, 1987; Feingold et al., 1988). The low body weight and sexual inactivity that is common to anorexic women suggests that the prevalence of pregnancy in this group is less common than one might find with women who are bulimic (MacDonald, D., 1996; Brinch et al., 1988). Physiological, as well as psychological factors, may affect the rate of pregnancy for women with eating disorders (Merlin, 1992).

There are several serious complications that can arise for both the mother and the fetus when a woman with an eating disorder becomes pregnant. There is clearly an increased risk to the pregnancy and to the developing fetus. However, the few studies that have been conducted with this population have reported findings which are conflicting. One of the most clinically significant of the many complications that can occur in a pregnancy where eating disorders have been influential is low maternal weight gain which, in itself, may also lead to further complications.

Maternal pre-pregnancy weight and prenatal weight gain are important indicators of nutritional status and have a major influence on pregnancy outcome. Continuing weight gain during pregnancy is considered to be a desirable indicator of maternal adaptation and fetal growth (Bennett & Brown, 1993). For many women, especially those in Western cultures, the idea of gaining weight is met with much apprehension (Goodman, 1995; Fahy & Morrison, 1993). Fairburn and Welsh (1990) studied primigravid women and found that 40% were anxious that they might gain too much weight, 28% had negative attitudes to changes in shape, and 72% reported a fear that they would be unable to return to their former weight after delivery. It was also reported that the fear of gaining too much weight was elevated in those women who had a previous history of dieting. For the woman with an eating disorder, weight gain subsequent to adequate nutrition and the changes in body shape may be that much more unsettling and therefore difficult for the woman to negotiate throughout pregnancy and during the postpartum period.

It is recommended that healthy women gain approximately 11 to 13 kilograms during pregnancy (Blackburn & Loper, 1992). There are numerous factors that may influence this weight gain including size of the fetus, amount of amniotic fluid, maternal metabolic rate, maternal edema, and smoking. Diet also has a significant influence on prenatal weight gain. Reduced maternal weight gain during pregnancy is associated with intrauterine growth retardation and increased fetal morbidity and mortality (Abrams & Laros, 1986). These complications are increased if a woman is of below average pre-pregnancy weight and has a poor nutritional status. This is often the case with women who have eating disorders such as anorexia nervosa and bulimia nervosa. Research confirms that many of the women who are underweight at conception give birth to low birthweight infants (Fahy & Morrison, 1993). Palmer and associates (1985) found that a strong fear of weight gain has been associated with lower actual weight gain in pregnancy. Women with eating disorders are known to have an intense fear of gaining weight. They also experience a disturbance in body image perception which plays an important role in the motivation of dieting and purging behaviour (Fahy & Morrison, 1993).

To date, a paucity of literature exists which looks at eating disorders during pregnancy and the subsequent maternal and neonatal outcomes. There appears to be a gap in the knowledge base and information available to health care providers who are interested in providing quality health care to women

in general, and specifically to those experiencing eating disorders during the perinatal period. Nurses can play an important role in the prevention of maternal and neonatal morbidity through the early detection of these eating disorders. If a greater awareness and understanding of this phenomena is achieved through research, women may be more willing to disclose their eating disorders, and therefore receive the appropriate referral and health care in order to receive an optimal state of health throughout their pregnancy.

## Purpose of the Study

In response to the lack of information found in the literature that relates to women with eating disorders during pregnancy, the purpose in this study was to describe and explore the experience of having an eating disorder during pregnancy. Initially an ethnographic analysis was planned and used to analyze the data. As an emerging basic social process was identified, a grounded theory approach was used to re-analyze and organize the data. Ten primary participants and two secondary participants were interviewed using an open-ended question/ semi-structured interview format.

### Research Questions

The following research questions were used to guide this study:

1. What is the experience of women who have an eating disorder--anorexia nervosa and/or bulimia nervosa--during pregnancy?
2. How do women with eating disorders--anorexia nervosa and/or bulimia nervosa--negotiate eating and nutrition in their pregnancy?

### Definition of Terms

Before proceeding with the significance of this research study, it is imperative that key definitions be elucidated. A universal definition of anorexia nervosa and bulimia nervosa would make diagnosis easier. However, health care professionals have not agreed on the defining criteria. For the purposes of this study, anorexia nervosa and bulimia nervosa were defined according to the criteria listed in the Diagnostic and Statistical Manual of Mental Disorders (1994). (See Appendix A). According to the DSM-IV, ***anorexia nervosa*** is characterized by: the refusal to maintain body weight over a minimal normal weight for age and height; the intense fear of gaining weight even though underweight; a disturbance in one's perception of body weight, size, and shape; and the absence of at least three consecutive menstrual cycles.

***Bulimia nervosa*** is characterized by: recurrent episodes of binge eating, or the rapid consumption of large amounts of food in a discrete period of time; a feeling of lack of control over eating behaviour during binge eating; the engagement in self-induced vomiting (purging), fasting, or vigorous exercise in order to prevent weight gain; a minimum average of two binge episodes a week for at least three months; and a persistent overconcern with body shape and weight. The term nervosa indicates that bulimia and anorexia are similar in that women who experience these disorders may have a distorted body image, an intense fear of fat, and the conviction that for self-acceptance, a slender body shape is crucial (Eating Disorders Awareness and Prevention, 1987).

## Significance of the Study

A review of the relevant literature was undertaken to determine the nature of the existing knowledge on eating disorders during pregnancy. Information on this topic is clearly limited and many gaps have been identified by the researcher. There were no studies located that described or explored how women with eating disorders negotiate eating or nutrition during their pregnancy. Epidemiological evidence of the harmful effects of eating disorders (anorexia nervosa and /or bulimia nervosa), both physiological and psychological, is unequivocal. The importance of providing and maintaining adequate nutrition during pregnancy is also unequivocal. While considerable work has been done regarding nutrition in pregnancy and, separate from this, eating disorders, the combination of these two conditions leads to a complex phenomena that has remained unexplored. Researchers report that the prevalence of eating disorders during pregnancy is increasing (Szmukler, 1985; Stewart et al., 1987). It is therefore a phenomena of considerable clinical significance and thus the need for this research study was substantiated.

In order to effectively provide a high quality of care, nurses as well as other health care professionals require an awareness and understanding of the unique experience of having an eating disorder during pregnancy. It is hoped that the results of this study will facilitate improved care to those women and their families who have eating disorders during their childbearing years. The results of this study also serve to enlarge the existing body of knowledge about eating disorders in combination with pregnancy. The results of exploratory research such as this generates additional questions and proposes theoretical relationships that will provide a foundation for further research specific to this area.

# CHAPTER II

## LITERATURE REVIEW

***That's what learning is. You suddenly understand something you've understood all your life, but in a new way.***
***Doris Lessing***

The purpose in this literature review is to examine, summarize and critically assess existing theoretical and research literature relating to eating disorders during pregnancy. A variety of areas of research are connected with the proposed research questions. Data bases searched include references from 1982 - February 1997 from MEDLINE, PSYCHLIT, CINAHL, and ERIC. A manual search of the Cumulative Index to Nursing and Allied Health Literature was completed from 1975 to 1982. Literature dated earlier than 1975 was included if considered classic and pertinent to this research. Terms searched were pregnancy, eating disorders, eating disorders and pregnancy, women's health, anorexia nervosa, bulimia nervosa, overeating, body image, birthweight, weight gain, fetal health, comorbidity, and nutrition and pregnancy. These terms were searched in relation to the antepartum, intrapartum, and postpartum periods of pregnancy, as well as in general. Personnel from eating disorder support groups and counselling services in both Edmonton, Alberta, Canada, and Vancouver, British Columbia, Canada, were also consulted.

It is beyond the focus and scope of this research study to critically examine pregnancy as well as anorexia nervosa and/or bulimia nervosa in great depth as independent conditions. These topics will be addressed in brief in order to provide enhanced knowledge and understanding of how the conditions of anorexia nervosa and bulimia nervosa have such a significant impact on the expectant mother. An introduction to the feminist perspective on eating disorders followed by a historical perspective of anorexia nervosa and bulimia nervosa will also be presented. The feminist perspective is presented to enhance the reader's understanding of the paradigm from which the majority of the literature on women and eating disorders is written and discussed. Following this insight into the world of anorexia nervosa and bulimia nervosa, research concerning eating disorders during pregnancy will be presented and analyzed.

## Feminist Perspectives

The women's movement is very concerned with diversity and complexity in understanding women's experiences in society (Rodriguez-Trias, 1992). One experience of women which is of great concern to feminists and women's health advocates is that of eating disorders. The traditional biomedical or psychiatric perspectives offer a narrow perspective of the problem, its course, and its treatment. A feminist approach to eating disorders and weight preoccupation recognizes how the conditions of women's lives shape their experience with weight and eating. The conditions of women's lives are what makes up both the predisposing and precipitating factors that lead to the development of an eating disorder.

To enhance understanding of feminist theory, it is important to consider how it has gradually developed from a body of experiences and perspectives about women's lives portrayed by female novelists, diarists, writers, scholars, filmmakers, and artists (Steen, 1991). From these sources a clear sense of women's stressors and problems, including eating disorders, have been derived. Feminism is defined by Chinn and Wheeler (1985) as "a world view that values women and that confronts systematic injustices based on gender" (p. 74). There are various feminist ideologies but common to them all are three basic tenets of feminist philosophy: (a) all women are oppressed, (b) the personal is political, and (c) awareness can achieve empowerment and emancipation (Speedy, 1991). It is only through the feminist lens that we, as individuals and as a culture, can begin to visualize and fully comprehend the complexity of the eating disorder phenomenon which is currently affecting women in epidemic proportions.

Eating disorders can be seen as reflecting how little control women perceive that they have over their lives (Boston Women's Health Book Collective, 1984). It may be that in controlling food and weight, women are exercising some degree of control over their lives. For many women, disordered eating leads to thinness which symbolizes autonomy and being attractive (Wooley & Wooley, 1986). The feminist perspective on eating disorders serves to reveal the underlying themes and meanings which food and eating hold for women.

The feminist movement of the late 1960's and early 1970's has enriched many women's lives and has also contributed to an enhanced feminist understanding of weight preoccupation. It was predominantly feminists who asked the commonly overlooked yet obviously critical question: Why were 95 percent of

anorexics and bulimics women? The answer to this question is complex (Susan Kano (1985); Marcia Hutchinson (1985); Eva Szekely (1988); Naomi Wolf (1991).

The prevalent theme in almost all the contemporary feminist writings is women's oppression in and through their bodies. A woman's body has been seen both as a source of power and liability. Women learn at a very young age that their body serves as a source of power--a means to an end. The danger in this is the conditional acceptance which they place on themselves and their bodies for their own self value and self worth. When a woman sees value in herself only through her body, the risk of losing herself to a world of self-hate, manifested in eating disorders, is a great and costly price to pay for societal and personal acceptance.

Feminists have been interested in eating disorders since the 1960's when a dramatic increase in the number of women diagnosed was evident (Orbach, 1982). In attempting to answer the question of the sociocultural impact on a disorder endemic to women, feminists have pointed to women's devalued position, sexism, the objectification of women's bodies in our consumer oriented society, and the perceived hostility towards everything associated with femininity (Chernin, 1981). Feminist writings have also addressed Western societies' harsh treatment of fat women and issues of power related to the preoccupation with weight (Szekely, 1988). For example, it has been suggested that women strive for a small and thin body because it occupies a minimum amount of space. A small woman is less visible, hence less threatening, and considered by men as more attractive than a large-bodied woman (Zerbe, 1993). In contradiction to the above stated notion, in other feminist writings, the notion of fat provides women with a certain kind of power, the power of safety (Orbach, 1982). Fat is a shell to keep out the rest of the world by essentially desexualizing oneself.

Several feminist writers have focused their analysis on women's changing roles and women's bodies as the arena in which attempts are made to resolve conflicts (Orbach, 1982; White, 1992). Women receive conflicting messages: to be traditionally feminine and to be masculine in that they must succeed in working outside the home. These conflicting messages may lead to an insecurity about one's own body. It is through this conflict that a woman may exert her sense of control on the one aspect of herself which she perceives as being entirely within her power-- eating. It then becomes clear how women begin the transformation from

acceptance of self when newly born to conditional acceptance of self and body based on society's ideals. For women, there is a struggle to form a sense of self that meets the multiple demands of society, loved ones, and personal ideals.

## Historical Perspective

Historically, women's social value has been closely linked with their bodies (Schwartz, Thompson, & Johnson, 1992). Women's roles were expressed through their bodies: in bearing children, satisfying men's sexual needs, and the labour of caring for men's and children's emotional and physical needs (Brown & Jasper, 1993; Zerbe, 1993). As changes occurred in women's social roles, so did their physical presentations. These changes are evident when reviewing the history of women, their social roles, and their preoccupation with eating, weight, and their body image.

Paglia (1991) theorized that during the Stone Age, a woman's social role was that of gatherer, nurturer, and mother. In this period anthropologists have postulated that there was little control over food supply or fertility at this time, and often food was scarce and mortality rates were high. A woman with a rounder, fatter body type was believed to be valued during this time potentially because she was more likely to be fertile (Paglia, 1991). Having an excess of weight was a matter of individual and community survival. This rounded fertile look for women continued to be emphasized towards the end of the Middle Ages and into the beginning of the Renaissance. There is evidence of this from artists of that time period, such as Raphael, da Vinvi, Titian, and Rubens (Seid, 1989). Women, portrayed by male artists, were signifying reproductive abilities and emphasis was placed on the belly, thereby exemplifying a fertile or pregnant look.

From the eighteenth century onwards, a number of significant changes occurred; food supplies were stable so indulgences were no longer forbidden, and the emerging industrial society brought about the need for women to "attract" male partners since "property" transfer, including arranged marriages, was no longer emphasized (Seid, 1989). Women began putting greater emphasis on their appearance in order to be attractive to men. Not surprisingly, the beauty ideal for women was an expression of this society's values and emphasized qualities of delicacy, gentility, slenderness, and etherealness (Romeo, 1986; Seid, 1989). The medical profession, dominated exclusively by men, reinforced these qualities by professing that women's digestive systems were too delicate for a hearty appetite (Seid, 1989). The thin, delicate appearance for

women was seen by society as a mark of gentility and implied that a husband or father had wealth. It also implied fragility, dependence, powerlessness, and being the property of rich men. It was seen as a freedom from having to do any hard manual labour and therefore a sign of urban success (Banner, 1983).

During the first thirty years of the twentieth century, a growing medical bias against fat developed (Seid, 1989). The fashion industry, guided by men, closely followed suite and began to standardize clothing sizes. The resulting implication for women was that if the size did not fit, their bodies were wrong (Wolf, 1991). Thus, a serious and complex investment by women in slimness emerged, evidenced in 1917 by the first best-selling book on weight control, namely Dr. Lulu Hunt Peter's *Diet and Health, with Key to Calories* (Seid, 1989).

During the time period encompassing the world wars, the slim yet curvaceous body ideal prevailed. This ideal continued until the late 1960's when the women's movement, along with various other movements of the time period, challenged the standards of beauty (Brumberg, 1988). Although the women's movement introduced the idea of variety in attractiveness, television was introduced to the public and subsequently served as a primary influence on what was considered beauty in North America (Garner & Garfinkel, 1978; Seid, 1989). Television, along with magazines and sophisticated advertising, communicated the beauty ideal of thinness for women. Not surprisingly, this corresponded with an increased incidence of anorexia nervosa and of bulimia in the 1970's (Vandereycken, 1994; Ziolko, 1996).

Eating disorders, however, were not a new phenomenon. Anorexia had been first diagnosed as a medical illness in 1874 by Lasegue in France and in 1873 by Gull in Britain. The first Canadian case reported was in 1895 (Seid, 1989). Anorexia remained obscure until the 1970's when, along with bulimia, it became practically epidemic among women. The medical and psychiatric professions benefitted dramatically from this epidemic since more women were seeking cosmetic alterations and psychiatric treatment (Brown & Jasper, 1993). What the health care professionals failed to recognize was that eating disorders went well beyond the classification of medical illness and presented a larger more complex women's issue. This "oversight" may, in part, be due to the masculine, medicinal lens which has traditionally been adopted in order to analyze any given illness or condition.

Of considerable interest is that women's fashion magazines continue to exhort women to "take charge" through controlling their body shape through eating. For most women this involves disordered eating, or not responding to the natural feeling of hunger. Today's women are exposed to the superwoman ideal--strong, muscular, thin, yet having large perky breasts. This image reflects what society views women's expected roles are in today's culture: the contradictory roles of the nurturing and caring mother; the soft, sexy, and giving wife; and the sexually independent, competitive, and ambitious career woman. The current body ideal embodies all of these qualities, conveying through the body the contradictions women face in their lives (Zerbe, 1993).

This historical perspective lends support to the idea that women have become pathologically preoccupied with their weight and eating which leads to eating disorders. It is with a greater awareness and understanding of these eating disorders attained through research that we may be influential in individually and collectively empowering ourselves and creating social change, thereby positively impacting on the current women's health epidemic of eating disorders.

## Overview of Anorexia Nervosa and Bulimia Nervosa

Eating disorders are now recognized as major medical and psychiatric conditions that affect millions of women in North America and Europe today. The weight preoccupation issues facing women today are complex (Carlson, 1995). Throughout a woman's life, she is apt to suffer from several weight related health risks associated with being overweight, losing weight, and being underweight, leading readily to eating disorders such as anorexia nervosa and bulimia nervosa (Klein & Dotto, 1993). It has been suggested that eating disorders may be one of the late 20th century's primary mental health issues such as hysteria was in Freud's time (Zerbe, 1993).

The diagnoses of anorexia nervosa and bulimia nervosa have been studied in great depth in many respects. There is still much to be learned and many more questions to be asked such as: What really constitutes an eating disorder? What is the cause? What other issues accompany an eating disorder? Can the sufferers recover from these disorders? and How can healthcare professionals help end the suffering? The literature related to eating disorders does suggest answers but frequently more questions are raised than have been answered. The amount of research that has been undertaken in this field is immense, but for the

scope of this research study, it is not feasible nor appropriate to do an in-depth literature review of both anorexia nervosa and bulimia nervosa as independent conditions. It is, however, important for the reader to have a preliminary understanding of the features of both conditions. The information presented is not all-inclusive but rather it is a summation of current research available on these dynamic conditions.

## Anorexia Nervosa

### Diagnostic Features

Anorexia is defined in the New American Webster Dictionary (1996) as "loss of appetite". This definition is a misnomer in that the loss of appetite is actually rare (American Psychiatric Association, 1994). The core feature of anorexia nervosa is an overwhelming drive for thinness, leading to attempts to maintain an emaciated body appearance. There is often a misperception of body size which may persist despite intensive treatment interventions, and this drives behaviours that cause physical and emotional problems. Individuals with anorexia nervosa refuse to achieve or maintain a minimal body weight for age and height (15 percent or more below what is expected). They may lose up to 25 percent of their original body weight. The primary dieting behaviour may be severe food restriction with a denial of hunger, excessive exercise, or some form of purging.

Anorexics fear becoming fat even when they are underweight. Their body image becomes distorted and they claim to feel fat when emaciated. The initial weight goal that starts the dieting process is often replaced by a need to lose weight, regardless of the emotional or physical cost. Amenorrhoea is common and periods stop for several consecutive cycles due to abnormally low levels of estrogen secretion and decreased pituitary secretion of follicle stimulating hormone (FSH) and luteinizing hormone (LH) (American Psychiatric Association, 1994; Putukian, 1994; Nattiv, A., Agostini, R., Drinkwater, B., & Yeager, K., 1994; Abraham, S., Mira, M., Llewellyn-Jones, D., 1990).

When anorexia nervosa was first documented and treated by physicians in the late 1800's, it was an illness of the religious, and fear of being fat was not part of its description (Bemporad, 1996). It exists today much as it did then--evoking feelings of awe and bewilderment in society, frustration in physicians, and fear and helplessness in both the affected individual involved as well as their family.

**Etiology**

Researchers have attempted to find a cause for anorexia nervosa, but to date there is no agreeable etiology for this condition. There is likely a strong psychological or pathological component. Social pressure to be thin contributes to the development of the condition (Szekely, 1988). Our society is peppered with such sayings as " You can never be too thin or too rich." Feelings of guilt, depression, and anxiety about not conforming to these beliefs only add to the problem.

Although researchers have not come to a conclusion on the etiology of anorexia nervosa, there appears to be three major theories. The first theory operates from a ego psychological perspective and argues that anorexia is a function of an impaired child-maternal environment in the early years of a child's life (Brunch, 1978). Anorexia is seen as an effort on behalf of the child or young woman, to gain perfect control over the body as a way of regaining control of self and personhood.

The second theory is the issue of control, also central to family system's theory (Munuchin, 1970). It was reported that anorexic families tended to be superficially nice and good, while covertly deeply enmeshed, overprotective, rigid, and unable to meet or manage conflict. The anorexic child sees loyalty and protection as taking precedence over autonomy and self-realization. The autonomy of the child or young woman is curtailed by the intrusive concern and overprotection of family members. Wooley and Wooley (1986) found that the more traditional a woman's family, the greater her risk for developing an eating disorder.

Proponents of the third major theory suggest that the etiology is organic. There is some primary endocrinological defect or trigger which precipitates the illness. Ideas about the relationship between increased body fat at puberty and the development of anorexia nervosa have been addressed in the literature (Boskind-White & White, 1983; Brunch, 1978). It has also been documented that starvation may actually be a sustainer of anorexia nervosa, physiologically producing psychological symptoms (Katz, 1985).

It is difficult to directly relate each sufferer of anorexia to one of the above stated etiological theories. It is possible that anorexia nervosa is the final common pathway of a number of etiological factors, and that each individual sufferer must be allowed to tell her story rather than linking her to a causative

theory. Symptoms may be associated with other conditions and early childhood experiences such as depression, anxiety, obsessive compulsive disorders, substance abuse and sexual abuse (Zerbe, 1993).

Depressive symptomology may be prominent for sufferers of anorexia nervosa (American Psychiatric Association, 1994). Their concentration and memory are often impaired as a result of the starvation process. Cognitive disturbances such as overgeneralization, extremes of "black or white" thinking and intense personalization are also present. Anxiety may be a natural consequence of both the psychological and physiological response to anorexia nervosa with the coping behaviour often presenting itself in substance abuse.

Obsessive Compulsive Disorder (OCD) has been frequently linked with eating disorders in the literature. Clinical similarities between obsessional personality and the dieting disorders have led to the contention that obsessional personality traits might predate the onset of the eating disorder (Smart, Beumont, & George, 1976). Thornton and Russell (1997) supported the assumption of obsessive compulsive comorbidity within the dieting disorders and provided empirical support that this obsessionality is a premorbid characteristic. With a sample size of 68 (35 with anorexia nervosa and 33 with bulimia nervosa), the results indicated that 21 percent of the sample met criteria for a diagnosis of obsessive compulsive disorder. In most patients, the obsessive compulsive disorder predated the dieting disorder. Previous studies have also supported the idea of comorbidity of anorexia nervosa (Thiel, Broocks, Ohlmeier, Jacoby, & Schuessler, 1995; Halmi et al., 1991; Laessle, Wittchen, Fichter, & Pirke, 1989; Fornari et al., 1992; Hudson, Pope, Yurgelun-Todd, Jonas, & Frankenburg,1987).

Documentation of the relationship between sexual abuse and eating disorders have become more widespread. There have been numerous researchers who have observed a connection between sexual abuse and eating disorders either through research or clinical practice (Bulik, Sullivan, & Rorty, 1989; Hall, Tice, Beresford, Wooley, & Hall, 1989; Bass & Davis, 1988; Beckman & Burns, 1990; Lacey, 1990; Oppenheimer, Howells, Palmer, & Chaloner, 1985; Sloan & Leichner, 1986; Wooley & Wooley, 1986). Contrary to clinical expectation, some researchers have shown that the rates of sexual abuse in eating disordered patients were comparable to those in other psychiatric patients suggesting that sexual abuse is not a critical factor in the development of an eating disorder (Pope & Hudson, 1992; Folsom et al., 1993; Welsh

& Fairburn, 1994). However, Zlotnick and associates (1996) found that inpatients with a history of sexual abuse are likely to present with eating disorder symptomology. Although the research is inconclusive, there may indeed be a relationship between eating disorders and a history of sexual abuse, and with further research it may be found to be more closely linked.

There are some other features which may be associated with anorexia nervosa which include issues of control, feelings of ineffectiveness, inflexible thinking, limited social spontaneity, and overly strained initiative and emotional expression (American Psychiatric Association, 1994).

**Course of Anorexia Nervosa**

The progression of anorexia nervosa begins with dieting which may occur as part of a major life change, such as moving, puberty, or loss of a boyfriend. The average age of onset for anorexia nervosa is 13 years, and most commonly in females around the age of puberty. If the dieting is successful, or the behaviour is reinforced in a perceived positive way, the individual begins to feel in control of her life once again. To make the dieting even more successful, she may begin to exercise excessively. The time devoted to physical exercise and activity may dramatically increase and is often paralleled by a gradual withdrawal from friends and social activities (Johnson, 1994). Internal control becomes a substitute for feeling helpless over external situations. The fear of losing control then becomes transferred to a fear of gaining weight (American Psychiatric Association, 1994).

**Consequences of Anorexia Nervosa**

The consequences of anorexia nervosa include both physical and psychological trauma of suffering from this disorder, not to mention the impact that it has on family and friends. Permanent physiological risks include damage to the heart, kidneys, gastrointestinal system, and brain (Kaplan, 1990). There may be lowered heart rate and body temperature/metabolism, dry pasty skin, irregular or absent menstruation, growth of fine downy hair on face and neck (lanugo), fatigue, swelling in extremities due to water retention, alopecia, bad breath due to ketosis, constipation, sleeping problems, and fainting or dizzy spells. Danger signals include: hair, nail, or skin problems, overuse of laxatives, social isolation, extreme weight loss, excessive physical exercise, an abnormal attitude toward food and denial of the problem (Canadian Association of Anorexia Nervosa and Associated Disorders, 1995). The greatest consequence of all is that

of death of the sufferer. It is reported that of individuals admitted to university hospitals, the long-term mortality from anorexia nervosa is over ten percent and is related to starvation, suicide, or electrolyte imbalances (American Psychiatric Association, 1994).

**Treatment**

The outcome of anorexia nervosa is variable (Zerbe, 1993). Professional care is necessary to treat the disorder. This may involve regular visits to a skilled physician, counsellor, or dietician. The treatment components may consist of psychoeducation and cognitive-behaviour therapy (MacDonald, 1995). Typically, other family members should also be counselled such as in the form of family therapy (Lackstrom, 1993). Treatment may also involve pharmacological therapy including such medications as antidepressants, antianxiety agents, prokinetic agents, vitamin supplements, and possible potassium supplements (MacDonald, 1995). It is possible, when treated early enough, for normal health to be regained. Self-confidence accompanied by a realistic body image can return the individual to productive living.

## Bulimia Nervosa

**Diagnostic Features**

Bulimia nervosa was first formally described in the late 1970's (Russell, 1979). Since that time it has attracted a considerable amount of clinical and research attention (Fairburn & Beglin, 1990). Bulimia nervosa is characterized by regular episodes of binge eating consuming large amounts of food in a short period of time, followed by a variety of behaviours to prevent weight gain (American Psychiatric Association, 1994). This unnatural, constant hunger or eating occurs in normal weight, overweight, and underweight people (Yanovski, 1991). Many bulimics have also suffered from anorexia nervosa (Canadian Association of Anorexia Nervosa and Associated Disorders, 1997). Behaviours to prevent weight gain may include self-induced vomiting, laxative, diuretic or enema abuse, fasting or excessive exercise. Regardless of body size, the individual remains preoccupied and distressed by her appearance and has a persistent concern for body shape and weight, often described as self loathing. Diagnosis is made using the DSM-IV criteria (Appendix A).

Bulimia nervosa has been reported as being ten times as frequent as anorexia nervosa. It may be more frequent than that as diagnosis of normal weight bulimia is difficult. Sufferers are usually ashamed of

their behaviour and may try to hide the symptoms thus remaining undiagnosed (Zerbe, 1993; Yanovski, 1991).

The most common characteristic of bulimia is induced vomiting after a large binging episode. Other symptoms can also be present. Behaviours such as fasting, amphetamine abuse, overuse of laxatives, misuse of diuretic medications, alcoholism or depression may be combined with bulimia (American Psychiatric Association, 1991). The episodes vary in frequency and intensity and appear to be precipitated by factors such as the breaking of self-imposed dietary rules, feelings of depression, anxiety, boredom or loneliness (Fairburn, 1991).

**Etiology**

There is no unified etiology for bulimia nervosa. Hypotheses for psychological causes of bulimia range from traditional psychoanalytical theories, such as impregnation fantasies, to feminist theories, such as the pursuit of thinness as an attempt to achieve an exaggerated feminine ideal (Yanovski, 1991). The impact of sociocultural influences on bulimia is well represented in the literature.

While anorexia nervosa and bulimia nervosa have both been linked to sexual abuse, substance abuse, depressive disorders, obsessive compulsive disorders, and anxiety disorders, there are differences within the reported relationships. It is reported that the personality traits of patients with bulimia nervosa differ from the distant rigidity and obsessionality of those women with anorexia nervosa. In the bulimic, there is a more turbulent emotional presentation with prominent impulsive behaviours in the areas of sexual activity and substance abuse (MacDonald, 1995). Although various literature sources have alluded to this differentiation between anorexic and bulimic women, no research studies were cited.

**Course of Bulimia Nervosa**

There has been remarkably little research conducted on the course of bulimia nervosa. It is suggested that bulimia usually begins with 'normal adolescent' dieting which becomes progressively more extreme (Fairburn, 1991). Bulimia may start with infrequent incidents of fasting followed by binge eating and intentional vomiting. The behaviour then escalates to a "binge-purge" cycle. Self-induced vomiting produces a sense of euphoria and a sense of control over one's feelings, especially those of depression and anxiety (MacDonald, 1995). Normal cues to eating decline. The typical sit-down meal is replaced by

"eating episodes". Infrequent bulimic events begin to increase over several months until incidents occur many times daily. Bulimic behaviour is reinforced by its neurotic consequences--the feelings of self-control, avoidance of weight gain and avoidance of confrontations with others over not eating.

**Consequences of Bulimia Nervosa**

The consequences of bulimia nervosa are varied. However, clearly both physical and psychological trauma can be identified, although in varying degrees. Bulimic women may experience physical symptoms such as: the erosion of dental enamel with subsequent dental caries; swollen salivary glands; gastrointestinal problems (bloating, constipation, abdominal pain); dehydration; electrolyte disturbances (sodium and potassium imbalance which can cause headaches, dizziness, and irregular heartbeat); epileptic seizures; weakness and lethargy; kidney damage; dermatitis around the mouth; amenorrhoea; water retention; ketosis; and broken blood vessels in the facial area (Canadian Association of Anorexia Nervosa and Associated Disorders, 1997).

The psychological damage of suffering from bulimia nervosa is difficult to quantify, but the impact to both the sufferer and their family and friends is immense. Follow-up studies of bulimic women are available and the interpretation of the data is difficult due to differences in diagnostic criteria and the lack of defined outcome measures. A true clinical state of patients is difficult to evaluate. Authors of one follow-up study reported that 40 percent of their patients had at least one relapse within a 15 month follow-up period, and only one-third of the patients had totally abstained from binge eating and vomiting (Mitchell, Davis, Goff and Pyle, 1986).

The mortality rate of bulimia is estimated at less than three percent (Patton, 1988). Causes for death from bulimia nervosa include cardiac arrhythmias, congestive heart failure due to ipecac induced cardiomyopathy, and complications of vomiting such as aspiration or esophageal tears (Patton, 1988).

**Treatment**

Bulimia nervosa requires professional treatment by a skilled physician, counsellor, and often a dietician. It is a chronic illness that may alternate between remission and relapse (Yanovski, 1991). Treatment usually occurs on an out-patient basis compared to hospitalization for anorexia. The "binge-purge" eating cycle can by replaced by learning new ways to manage needs and feelings. This is

accomplished through psychotherapy and a cognitive-behavioural approach, often provided in group therapy. Pharmacological therapy is also used and includes antidepressants, prokinetic agents, vitamin supplementation, potassium supplementation, and fibre therapy for constipation (MacDonald, 1995).

Cases unresponsive to therapy are associated with a mortality rate of 3 to 20 percent. Chronic forms of bulimia develop in approximately 25 percent of patients (British Columbia Eating Disorders Association, 1994). These disorders seldom respond quickly to treatment so it is crucial to continue to build faith and hope within the sufferers and their family and friends.

## Eating Disorders During Pregnancy

Eating disorders during pregnancy have significant physiological and psychological implications for both mother and baby. Since it is not the focus of this study to research the impact of eating disorders prior to the pregnancy, attention will be primarily focused on the prenatal and postnatal periods. The physiological and psychological effects of eating disorders during and post pregnancy will be presented as they appeared within the reviewed literature.

Many of the psychological conflicts that are considered to be prevalent in women with eating disorders are highlighted during pregnancy. Some of these conflicts include concerns about adult sexuality, body image, autonomy, dependency, and relationships (Stewart et al., 1987). The increased physical changes and demands of pregnancy, coupled with psychological conflicts may exacerbate the eating disorder.

Stewart and associates (1987) found that those women who were anorexic at the time of conception experienced a worsening of psychological symptoms, including anxiety, depression, and an increased concern about body weight and shape. These women typically lost weight rapidly following their delivery and returned to their pre-pregnant weight within a few weeks. This finding is supported by Fairburn and Welsh (1990) who also report the rapid weight loss of postpartum women who have been preoccupied with weight and shape. Stewart and associates (1987) also report that women who were anorexic prior to conception did not experience the worsening of symptoms that the active anorexics experienced. It was also found that the women with eating disorders in remission gained more weight throughout their pregnancies than did those with active anorexia nervosa or bulimia nervosa. In this study, the average birthweight of

infants of anorexic mothers was 2744 grams, in comparison with 2363 grams for bulimics and 3592 grams for women who had recovered from eating disorders. Infants of mothers were reported to be more likely to be delivered prematurely and have lower Apgar scores.

Although this study supported the hypothesis that there is a poorer outcome for women who have active eating disorders during their pregnancies, limitations exist due to the small sample size that was used (n=23, bulimic women=3). The results of this study were supported in another study which suggested that childrearing women were at a key age for the development of an eating disorder, and those who have been preoccupied with weight and shape before becoming pregnant may continue to be so during pregnancy and may begin to diet or purge, causing fetal risk (Mitchell, Soen, Gollater, Soll, & Pyle, 1991).

Treasure and Russell (1988) reported that there was diminished fetal growth during the last trimester, as assessed by serial ultrasonography. The seven infants in this study had abdominal circumferences below the third percentile at birth. The anorexic mothers had an average maternal weight gain of eight kilograms. The authors suggest that there is an association between poor maternal weight gain with women who experience eating disorders and low infant birthweights. It is difficult to determine the validity and reliability of this study since the methodology was not addressed and replicability of this study is not possible given the information provided by the authors. In addition to this, further limitations to this study include a small sample size (n=7) and a lack of operationally defined variables.

The negative psychological effects of having an eating disorder may be counterbalanced by the mother's concern for the health of the fetus. This may lead women with eating disorders to suppress the need to diet or binge. In the study by Lacey and Smith (1987), consisting of 20 untreated bulimic women, it was found that bulimic behaviour decreased during pregnancy so that by the third trimester, 75 % of the women had stopped binging and vomiting. The symptoms did return shortly after delivery and for approximately half of these women, eating was found to be more disturbed. Drawing statistically significant results from this study is difficult due to the small sample size (n=20) and because extraneous factors such as heredity and substance abuse were not controlled. The significance of the results were not discussed.

This research does not support the findings resulting from earlier studies such as the one conducted by Stewart et al. (1987) whereby a worsening of the eating disorder occurred during pregnancy. It does,

however, suggest that women with eating disorders during pregnancy may have increased motivation, as a result of the concern for the fetus, to suppress their disorder during this critical prenatal period.

Further research will need to be conducted in order to ascertain why some women appear to be successful at suppressing their eating disorder during the prenatal period while others are not successful. The return to active anorexia nervosa or bulimia nervosa following delivery will also need to be explored. It is of critical importance that the variables being studied are operationally defined so that comparisons between study results can be addressed.

Eating disorders during pregnancy have also been associated with obstetrical complications both during pregnancy and at birth (Weinfeld et al., 1977; Treasure & Russell, 1988; Fahy & O'Donoghue, 1991). Outcome studies confirm increased rates of difficult labours often ending in medical intervention (Stewart et al., 1987; Fahy & Treasure, 1989). These pregnancies are often considered to be high-risk. In a retrospective study conducted by Lacey and Smith (1987), high rates of breech presentation and hypertension were found in the study sample of 20 bulimic women. Of the 20 women studied, nine reported hypertension and eight reported breech deliveries. There was also multiple births recorded in this study. Brinch et al. (1988) studied 50 anorexic mothers and found that out of the 86 children born to these mothers, seven babies died within one week of delivery: five from complications of prematurity, one from hydrocephalus, and one was stillborn. Fourteen percent of these infants were born below 2500 grams and therefore were considered to be low birthweight infants, a percentage twice the expected rate. The researchers also demonstrated a perinatal mortality rate that was six times the national rate at that time.

Congenital malformations and perinatal mortality have also been associated with lack of maternal nutrition in the literature. The recent literature raises concerns about this lack of nutrition of anorexic and bulimic women and the possible teratogenic risks that this may pose to the fetus. Lacey and Smith (1987) found an excess of abnormalities in their study sample which included the 22 infants born to bulimic mothers. The research suggests that weight loss in association with vomiting poses an added risk. Further to this, additional risks include the abuse of appetite suppressants and laxatives that are commonly used by women with bulimia nervosa. This problem needs to be further addressed in research which takes into account all of these possible teratogenic influences.

There have been few studies that have addressed the parenting skills of women with eating disorders. It is important to address the longitudinal effects of anorexia nervosa and bulimia nervosa on parenting since there is some evidence which suggests that these eating disorders may affect growth and development during the infant and preschool periods. Brinch et al. (1988), in their follow-up study of 50 anorexic mothers, found that 17 % of children experienced failure to thrive during the first year of life, as reported by their mothers.

Contrary to these findings, Treasure and Russell (1988) report that in their study of intrauterine growth and neonatal weight gain in babies of women with anorexia nervosa, the babies growth increased in the neonatal period despite a degree of intrauterine malnutrition. Stein and Fairburn (1989) found that the children of five bulimic mothers in the study were not being provided adequate nutrition. The mothers in this study were concerned about their children's weight and shape, although it was found that one child was severely underweight and another was obese. The mother's disordered eating habits and attitudes seemed to interfere with parenting ability. These mothers also had difficulties with breastfeeding. Three of the women felt that breastfeeding was distasteful and one mother was required to stop due to reported insufficient milk supply. Findings showed that the feeding and general development of the children of mothers with bulimia were adversely affected.

Fahy and Treasure (1989) reported that in treating bulimic women "the conflict between the demands of childrearing and the bulimic disorder creates a great deal of tension in the mother-child relationship" (p. 1031). The mothers in this study feared that their own eating behaviours would lead their children to also develop eating disorders later in life. The mothers experienced difficulty feeding their children due to their own difficulties in dealing with food. The children in this study were reported to be developing normally.

In summary, little is known about women who experience eating disorders during their pregnancy and their subsequent pregnancy outcomes. The studies that have explored this phenomena have also reported conflicting results. This may be related to the many limitations that exist in research studies, including small sample sizes and variables which have not been consistently operationally defined.

Studies that explored and described the experience for women of having an eating disorder during their pregnancy were not located. Qualitative research about eating disorders during pregnancy is clearly lacking. The lack of research may be due to a lack of awareness of the phenomena, perhaps resulting from the reluctance of women to disclose the information. In this research study, some of these gaps in research will be addressed specifically those relating to women's experience of having an eating disorder during their pregnancy. It is hoped that this will, in turn, increase awareness of eating disorders during pregnancy and postnatally, as well as increase knowledge and understanding of this phenomena so that health care professionals, and women who experience eating disorders during their pregnancy, may benefit from the findings.

# CHAPTER III

## METHOD

***Our view of reality is like a map with which to negotiate the terrain of life. If the map is true and accurate, we will generally know where we are, and if we have decided where we want to go, we will generally know how to get there. If the map is false and inaccurate, we generally will be lost.***
***M. Scott Peck***

When choosing a methodology for a research endeavour, the researcher must select a method which will appropriately describe the phenomena to be studied. Both the nature of the research question and the maturity of the concept, or how much has been investigated about the topic, must be considered by the researcher when making this decision (Field & Morse, 1985). The purpose of this research study was to explore and describe the personal experiences of the participants from which primitive concepts or constructs could be generated, namely the experience of having an eating disorder during pregnancy. The experience of having an eating disorder during pregnancy does not appear to have been sufficiently explored. Therefore, a qualitative research methodology was chosen for this study given that this approach is indicated when there is either no knowledge or limited knowledge about a phenomenon.

Qualitative methods are also indicated when the researcher wishes to explore and describe a phenomenon from an emic perspective, that is, the perspective of the person experiencing it as was true for this research study (Field & Morse, 1985). Qualitative methods are aimed at discovering meaning in context and are necessary to develop knowledge for nursing practice. In a practice discipline such as nursing, inquiry must begin with identifying and isolating relevant factors, rather than trying to explain or predict imposed variables (Diers, 1979). The generation of the concepts or constructs resulting from this research study may serve to provide other women experiencing eating disorders during their pregnancy, as well as health care professionals providing care for this population, with an increased awareness and understanding of this important, yet poorly understood, phenomena. In this chapter, the methodology of this research will be presented. The specific qualitative approach used in this investigation will be addressed, as will the research design, issues of reliability and validity, and ethical considerations.

## Qualitative Method: Exploratory-Descriptive

In this study, an exploratory-descriptive design was employed using an ethnographic approach for interviewing, data collection and analysis. The researcher collected, described, and analyzed data in order to provide insight into human behaviour and to determine the meaning and experience of women of having an eating disorder during pregnancy. Description, with identification of commonalities across interviews, was an initial step in developing an understanding of the participants experiences with an eating disorder during pregnancy. This information will enable nurses to recognize and evaluate the needs of women with eating disorders during their pregnancy and assist them in the development of strategies leading to quality human experience (Aamodt, 1989).

## Research Design

The research design of this study will be addressed through discussions of the sample, methods of data collection, and techniques of data analysis.

### The Sample

A purposive convenience sample of women with eating disorders during their pregnancy was obtained using information letters at an eating disorder clinic and through advertisements in three local newspapers. The purposeful sample was selected according to the needs of the study (Morse, 1991). The women called the listed phone number (placed on the information letters and in the newspaper advertisement) and were then screened using the inclusion and exclusion criteria. If suitable, the participants were selected for the study. Selection of participants was necessary to facilitate the acquisition of data that provided the quality and rich descriptions required to identify the themes around the phenomena of eating disorders during pregnancy (LeCompte & Goetz, 1982; Morse, 1989). The qualities of a "good informant" are the possession of knowledge about the topic under study, an ability to reflect upon an experience and provide information about the phenomenon, and the willingness to share experiential information with the researcher (Morse, 1989). All of the women participating in this study possessed these qualities.

As concepts and categories requiring validation emerged from the data and coding, participants were selected on the basis of any additional information they could provide. The ideas presented by the participants formed the basis of the description, as well as "generating a plan for recognizing and evaluating

the needs of individuals and groups of individuals" (Aamodt, 1989, p.38). This qualitative research method allowed the researcher to value the uniqueness of each individual while seeking out commonalities within the study group (Thorne, 1991).

**Recruitment of the Sample**

Twelve participants (ten primary and two secondary) were recruited using a variety of methods. The inspiration for this study, a personal friend suffering from an eating disorder during her pregnancy, comprised the first primary participant. The researcher was approached by this participant while undertaking graduate studies with the hope of receiving enlightening and optimistic information about the experience of other women who have had eating disorders during their pregnancies. At this time she was merely contemplating becoming pregnant but wanted to be informed of the potential risks to both herself and her baby prior to conceiving. After the literature revealed that few studies had been conducted on this topic, the researcher began her quest for increased knowledge and understanding regarding this phenomena.

Additional participants were recruited in three ways. First, participants were recruited from an eating disorder clinic in the city. Three primary participants who met the inclusion criteria were found through this method. Second, participants were sought through advertisements in three local newspapers. Five of the primary participants and the two secondary participants who met the inclusion criteria were found through this method. Third, one of the primary participants meeting the inclusion criteria was found through snowballing, or the referral from one participant already participating in the study. Upon telephoning the researcher, the potential participant was read the Information Letter (Appendix C) and any initial questions or concerns were addressed at this time. Primary screening took place by the researcher to ensure that the potential participant met the inclusion criteria for the study. If the contact was interested in participating, a time was arranged when the researcher and potential participant could meet to further discuss the study. If the participant agreed to take part in the study, an Informed Consent was obtained. All participants who met with the researcher agreed to take part in the study. Once the Informed Consent Form (Appendix D) was discussed and signed, the Background Data Form (Appendix F) was completed and the first interview was conducted at a mutually convenient time.

The researcher attempted to gain access to self-help groups such as eating disorders anonymous and overeaters anonymous with the intent of providing the leader of the group with information letters. However, it was decided by the Board of Directors of these groups that making contact with anonymous self-help groups breaks their policy of anonymity and therefore access was denied.

It is important to note that the researcher received numerous phonecalls from women who experienced compulsive overeating during their pregnancy (n=6). As they did not meet the criteria for the study, they were not invited to participate. There were some potential participants who did meet the criteria for inclusion in the study (n=5) but chose not to participate because of the clause in the Information Letter (Appendix C) and the Informed Consent Form which refers to the Child Welfare Act (Appendix D). The reasons given by the informants were prior negative experiences with Family and Social Services. The researcher did not ask these individuals to elaborate further due to the belief that it would be unethical to do so.

**Selection Criteria: Inclusion**

Selection criteria for a participant's inclusion in this study include:

1. Current experience with an eating disorder (anorexia nervosa and /or bulimia nervosa) during pregnancy or past experience with an eating disorder during pregnancy (not greater than ten years ago).
2. Having met the Eating Disorders Diagnostic Criteria (Appendix A).
3. The ability to speak and understand English.
4. Cognitively able to reflect on and verbalize experiences related to the topic.
5. Living within city limits.
6. Over the age of 18.

**Selection Criteria: Exclusion**

Selection criteria for a participant's exclusion in the study include:

1. The absence of any one of the above stated inclusion criteria.

2. Those individuals with physical illnesses (e.g. Diabetes Mellitus) or those having received pharmacological treatments (e.g. steroids) that are known to influence an individual's eating, shape, and weight.

3. Those individuals with a medical diagnosis of hyperemesis gravidarum.

**Sample Size**

The sample size for this research study was not predetermined because in qualitative research the data required and thus the sample size varies with the aim of the study and the breadth of the inquiry into the subject area (Agar, 1986). The sample size is a function of the qualities of the participants and of the interviewer's skills because these factors influence the quality of the data (Morse, 1986). Interviewing ceased when additional participants did not provide any new information beyond that already obtained by the researcher (Field & Morse, 1985). As well, the researcher decided that the sample size was adequate when the data obtained was sufficiently detailed to enable the researcher to answer the research questions. Participants were recruited on an ongoing basis and data were analyzed concurrently so that the researcher knew when categories appeared to be saturated (Morse, 1986).

**Characteristics of the Sample**

Biographical information was collected from each participant on a Background Data Form (Appendix F) in order to further describe the research sample and to begin to understand the context of the participant's world. It is important to note that the information collected in this manner was not deemed relevant to the developing category and theory unless it emerged from the data during data analysis (Glaser, 1978). The ten primary participants represent a diverse population in terms of age, education, and parity. All participants were Caucasian.

The primary participants ranged in age from 26 to 38 years with a mean age of 31.4 years. Seven participants were married, two were divorced, and one was living in a stable common-law relationship with a history of divorce. Six of the participants worked outside the home, one worked as a homemaker, one was self-employed within the home, one was currently unemployed, and one was on disability due to her eating disorder and obsessive-compulsive disorder. All participants completed high school, one had taken some

post-secondary courses, two had diploma's from a technical school, two had university degrees, and one had taken courses at the graduate level.

Of the ten primary participants, five had diagnoses of anorexia nervosa--restricting type, three had anorexia nervosa--binge-eating/ purging type, and two had bulimia nervosa--purging type. Seven of the ten participants reported their eating disorder to be currently active, two reported being in remission, and one who was pregnant during the time of interview reported being in remission during pregnancy but otherwise active. The methods used to control weight included: exercise, restricting intake, purging, the use of laxatives/diuretics/stimulants, and cigarette smoking.

The age of onset of anorexia nervosa ranged from 11 to 15 years of age with a mean age of onset of 12.4 years. The bulimic participants' age of onset was 15 and 17 years of age with a mean age of onset of 16 years.

The majority of the participants have been treated for their eating disorders (n=8), with the exclusion of two participants who have chosen not to disclose their disorders. For those that have received treatment, the type of treatment varied and included such things as: support groups, pharmacological therapy, and therapy with dieticians, psychologists, and psychiatrists. Three of the ten participants have been treated on an inpatient basis. There were no confirmed family histories of eating disorders although three participants suspect that there may be individuals in their family who demonstrate signs and symptoms of an eating disorder.

The participants varied in their gravidity and parity. Three of the participants were pregnant at the first interview and all three were at a gestational age of 34 weeks. This pregnancy was the second for one of the participants, and the third pregnancy for the other two participants. Five of the participants were first time mothers, one had two children, and one had three children although one pregnancy was a twin pregnancy undiagnosed prenatally.

Of the ten women interviewed, three had histories of premature deliveries and two had histories of spontaneous abortions. One of these had had multiple miscarriages due to "fertility problems". Three of the ten participants (anorexic by diagnosis) had experienced mild morning sickness during one of their pregnancies, lasting only for the first trimester. One of the ten participants was a smoker. All deliveries

were vaginal deliveries, three with assist by vacuum extraction and one with a forceps extraction. Complications of the intrapartum period varied from no complications to reported prolonged labours, meconium for fetal distress, undiagnosed twins, face presentation, fourth degree tears, and fainting during labour.

Maternal weight gain and prepregnancy weights varied. The range in maternal weight gain for the participants with anorexia nervosa was from nine pounds to 48 pounds. The prepregnancy weight ranged from 92 to 128 pounds. For the women with bulimia, the maternal weight gain was 28 and 45 pounds. The prepregnancy weights were 114 and 130 pounds. Weight control measures used during pregnancy included: exercise (n=5), restricted nutritional intake (n=7), purging (n=1), diuretics (n=2), laxatives (n=1), and stimulants (n=1).

All of the children born to the participants are reported as being healthy and happy children. Only two of the ten participants chose not to breastfeed, one of whom was unable to breastfeed due to medication that she was taking for her obsessive-compulsive disorder. The birthweights of the premature babies born between 33 and 37 weeks ranged from 3 pounds, 1 ounce to 6 pounds, 4 ounces. For term babies, the birthweights ranged from 6 pounds, 9 ounces to 8 pounds, 8 ounces.

A graphic presentation of the characteristics of the sample can be found in Appendix G.

## Data Collection

### Interview Process

The interview method was appropriate for data collection in this type of study as interviews allowed for self report of participants' perceptions and experiences, flexibility in question order, and clarification of questions as needed (Brink & Wood, 1989). This method also had the advantage of direct verbal interaction with the participants allowing for immediate feedback (Borg & Gall, 1989). Explanations and clarification were given as needed to ensure that the participants understood the topic, questions, and terms. Participants did not seem to experience difficulty answering the questions but rather expressed intense emotion while answering and exploring the questions.

At the beginning of the interview with each participant, the study was again explained to the participants and informed consent was received (Appendix D). Biographical data about each participant was

then collected on a Background Data Form (Appendix F). Although the data serves to describe participants in greater detail for the readers of the study, it is important to note that this information was not deemed relevant to the developing categories unless it emerged from the data during data analysis (Glaser, 1978). Collecting biographical data at the beginning of the interview served to "break the ice" and enabled both the interviewer and participant to relax into the interview milieu.

Interviews were semi-structured using open-ended questions (Appendix E). A combination of questions were used in order to provide consistency to the data (Brink & Wood, 1989). The questions were general which allowed the participant to explore her experiences without influence from the researcher. As no suitable instrument for the attainment of women's experiences of having an eating disorder during their pregnancy exists, the researcher developed an interview schedule. Relevant information from the literature and consultation with health care professionals were used as the basis for development of appropriate questions, thus providing content validity for the interview guide.

An informal, friendly, but purposive atmosphere was maintained throughout the interviews to minimize participants' awkwardness with the interview situation (Agar, 1986; Spradley, 1979). The researcher made a conscious effort to allow participants to voice their thoughts and feelings without interruption. Prompts were used especially at the beginning of interviews, in order to add depth and richness to the data and to ensure that all aspects of the experience of eating disorders during pregnancy were covered. As each interview progressed, fewer prompts were necessary with all participants. Several prompt questions were added after the first two interviews were analyzed in order to clarify and verify data collected from those participants previously interviewed (Appendix H). These additional questions were introduced only after the participants had spontaneously answered the question in the interview guide. All questions seemed to make sense to the participants and elicited the information asked for by the researcher. Thus face validity was established for the interview guide.

Interviews were between 45 minutes and two hours in length, with most interviews lasting approximately one hour. This time period is typical of interview length in other research studies and seemed appropriate for the participants in this study. The interview which lasted two hours was allowed to continue for this extended time because it was the desire of the participant to continue to describe her experience.

Secondary interviews were conducted only to verify and clarify data collected from the first interview. As all necessary information was obtained after a maximum of two interviews, the researcher decided that third interviews were unnecessary. Only three of the primary participants were interviewed a second time.

All interviews were tape-recorded. Field notes were recorded immediately following each interview. These included the researcher's observations about characteristics of the setting, context, length of interview, nonverbal communication occurring during the interview, and interruptions or other factors that were felt to influence the interview. The field notes also reflected the researcher's thoughts and interpretations about the interview. Following each interview, interviews were transcribed verbatim by a typist and non-verbal observations from field notes were added and placed in brackets. During data analysis, the field notes were used to assist the researcher to understand the context in which the interview took place (Field & Morse, 1985).

A personal diary was also kept during the study which included the researcher's subjective thoughts and feelings. This allowed any personal biases to be identified and set aside using this "bracketing" technique.

**Interview Setting**

Participants were interviewed at their home, or in one case, at a friend's home, as requested. By allowing participants to choose the location of interactions, they were able to gain some control early in the relationship and the familiar surroundings may have contributed to the relaxation and comfort level felt by the participants during the interview. Each participant was interviewed alone at the request of the researcher in order to facilitate confidentiality, encourage full expression of ideas, and minimize influences on responses to questions (Morse, 1986). The participant who was interviewed at a friend's home requested that the friend remain present in her own home given that she was influential in this participants healing. The participant felt that she could talk openly and honestly with her friend present. The friend chose to remain in a separate room throughout the duration of the interview at her own discretion. Occasional disturbances occurred during some of the interviews when either the telephone rang or children came into the room for brief periods. The interview was paused and re-commenced after the disruption. On one occasion a

phonecall caused the participant to forget what she was saying prior to the disruption, therefore interrupting the flow of the interview. The flow of the interview was re-established using a prompting question.

## Data Analysis

Data analysis occurred simultaneously with sampling and data collection. This was continued until no new information or relationships were evident in the data or the point at which all of the major concepts had been explored and no additional information emerged to further develop a category (Field & Morse, 1985; Glaser, 1978; Glaser & Strauss, 1967; Strauss & Corbin, 1990). Thirteen interviews with ten primary participants and two interviews with two secondary participants were completed by the researcher over a six month period. The transcribed data was hand-coded by the researcher in order to structure the data obtained from the interviews. Each participant's transcript was colour coded, one colour to designate the participants and one to designate the interview. In the initial stage of analysis, the researcher read each transcript and searched for themes. An example of a theme in this study was 'fear'. The researcher then reviewed each transcript in detail, line by line, and identified codes or units of analysis which were then written in the large right hand margins of the transcript. An example of a unit of analysis in this study was 'fear of being fat'. These units or codes were then transferred to a separate sheet of paper and arranged into categories by commonalities in subject matter. As the codes appeared in the interviews, the participant colour, interview colour, and page number were recorded on the code sheet as well as being coded on the interview transcript. The data was then surveyed for phrases, sentences, or anecdotes central to each category so that adequate descriptions of categories were attained. A cut-and-paste approach was used to organize data. Excerpts from transcripts were cut out and placed in a large file folder with sections for each of the identified categories. Descriptors for each category were then compared within interviews for each participant as well as compared across interviews with other participants.

As the interviews progressed, the researcher was able to use the data obtained from previous interviews to guide interviews with new participants allowing for further exploration and clarification of emerging themes. In this way the researcher was able to validate and clarify information as data collection and analysis proceeded (Boyle, 1989; Field & Morse, 1985).

The important categories describing the experience of having an eating disorder during pregnancy became evident after the interviews with the first three participants. These core categories were validated, without prompting, by the rest of the primary participants, as well as by the two secondary participants. From the data, a story line reflecting the categories and possible process involved in the experience of having an eating disorder during pregnancy was developed. While the researcher did not set out to develop a grounded theory, a basic social process of "Protecting" was identified. Antecedent conditions, action/interaction strategies, factors influencing "protecting", and consequences or outcomes of this process also emerged from the data.

Theoretical notes, or memos were written by the researcher during the data analysis procedures and upon reflection of fieldnotes. These notes recorded the researcher's thoughts and ideas about the data and categories and helped the researcher identify important information not clearly spelled out in the data (Miles & Huberman, 1984; Field & Morse, 1985). Descriptors for each category were noted in the margin as the interviews progressed.

## Issues of Reliability and Validity

The reliability and validity determines value and credibility of any study (Brink & Wood, 1989; Field & Morse, 1985). Reliability and validity of data are important to establish in both quantitative and qualitative research, although the criteria used to assess the reliability and validity of the data findings vary with the approach (Field & Morse, 1985). In qualitative research, reliability refers to the consistency of the information over time, while validity refers to the "extent to which the research findings represent reality" (Field & Morse, 1985, p. 139). Criteria outlined by Guba and Lincoln (1981) and adapted by Sandelowski (1986) were used to assess rigor in this qualitative research study and to establish trustworthingness of the data. These four criteria include credibility, fittingness, auditability, and confirmability.

### Credibility

Credibility, or truth value, is the degree to which findings actually represent the reality of the phenomenon being studied (Sandelowski, 1986). Several strategies were used by the researcher to enhance credibility. First, the researcher met with participants prior to conducting the interview. The location of the interviews was determined jointly by the participant and the researcher. Interviews were conducted in a

private room so that there were no interruptions and conversations would not be overheard. Participants were interviewed without others present. All of these techniques aided in the establishment of rapport and the development of trust with each participant, which in turn added to credibility (Field & Morse, 1985).

Secondly, participants were recruited from a variety of sources which helped to ensure that the responses of the participants were not context-dependent. It is assumed that the participants were able to talk accurately about their experiences and that their responses were trustworthy as there was no benefit to participants if they were dishonest.

Thirdly, participants were presented with the possibility that a second or third interview would be held if the participant and /or researcher believed that one interview was not sufficient to cover the questions in the interview guide or if the researcher felt that it was necessary to verify earlier responses and thus add depth to previously collected data.

Lastly, the findings derived from the data were given to one primary participant and one secondary participant to see if the researcher's perceptions of the data fitted with the participants' experiences. In both cases, the participants agreed with the descriptors obtained for the categories.

Pre-existing biases of the researcher have the potential to influence the credibility of the results (Guba & Lincoln, 1981). For this study, the researcher had no specific expectations of what participants would say about their experience of having an eating disorder during pregnancy, nor did the researcher have any specific hypotheses to prove. The researcher also had no biases from reading previous research as the research on this topic is lacking. Thus pre-existing biases which could invalidate the results of this study were not deemed to be a problem.

## Fittingness

Fittingness refers to the applicability of the research findings (Sandelowski, 1986). According to Morse (1989), the appropriateness and adequacy of the sample is critical to the quality of the research. Appropriateness is "the degree to which the choice of participants and method of selection 'fits' the purpose of the study as determined by the research questions and the stage of the research" (Morse, 1989, p.122).

Sample selection in this study was guided by the researcher's attempt to find "expert" participants who were willing to articulate their experiences of having an eating disorder during their pregnancy.

Adequacy refers to the quality and sufficiency of the data (Morse, 1989). The researcher assessed the participants' answers for relevancy, completeness, and amount of information. The researcher asked for the same description with different questions and prompts at different interviews. To ensure adequacy, the researcher ceased sampling only when the categories became similar and repetitive and no new categories or interpretations were obtained (Field & Morse, 1985).

Content analysis of interview data was initially done with the assistance of a thesis committee member to ensure that relevant data were accurately categorized. Double-coding took place whereby the researcher and thesis supervisor independently coded the same segment of data and compared results. The coding procedure was also assessed using code-recoding whereby the researcher coded a segment of the data and returned to it two weeks later to compare results. In addition, one primary and one secondary participant were chosen to validate the categories.

## Auditability

Auditability refers to the ability of another researcher to clearly follow the "decision trail" used by the researcher in the study (Sandelowski, 1986, p.33). In order to promote auditability, a detailed description of how the study was done, including the questions asked in the interview, is provided. Interviews were audio-taped, fieldnotes were written following each interview, and theoretical notes or memos were recorded during data analysis. These techniques allow other researchers to assess the credibility of the method and the research findings and thus enhance auditability.

## Confirmability

Confirmability refers to the meaningfulness of the findings of the study. According to Sandelowski (1986), confirmability is achieved when credibility, fittingness, and auditability are established. Confirmability was enhanced by having the research findings validated by two participants to help ensure that the interpretations of the data are seen not only by the researcher, but are also evident to others. Confirmability will be further determined when the findings of this study are reported and others find them useful.

## Ethical Considerations

Several strategies were used by the researcher to ensure that this study was conducted in an ethical manner. These strategies include obtaining ethical approval from the Ethics Review Committee, receiving informed consent, ensuring confidentiality and anonymity, exploring the risks versus the benefits of the study.

### Ethical Review

The researcher received ethical approval for this research study from the Joint Faculty of Nursing/University Hospitals Ethical Review Committee of the Faculty of Nursing, University of Alberta.

### Informed Consent

After receiving information regarding the purpose, procedure, and time commitment of the research study via both the Information Letter (Appendix C) and the Informed Consent (Appendix D), each participant participating in the study signed the written Informed Consent Form (Appendix D). Informed consent is premised on a special relationship of trust and requires an ongoing relationship of effective communication (Rozovsky & Rozovsky, 1990).

The consent form was assessed by the Right-Writer computer program and is below a grade eight reading level. Although participants were provided the opportunity to ask the researcher any questions about the research study prior to signing the Informed Consent, and as well throughout the interview, no participants had questions. All informants were told that they had the right to decline to participate in the study, that they were free to withdraw from the study at any time, and that they would not be identified by name in the study. No informants withdrew from this study. All participants were provided with a copy of both the Information Letter and Informed Consent to keep for their own records.

### Confidentiality

Confidentiality in a research study is an important ethical consideration. Confidentiality of all personal information including any written materials, audio-recorded tapes and transcripts were guaranteed. Only the researcher, her transcriber, and her thesis supervisor had access to the raw interview data. These individuals agreed that the information would be kept confidential.

Informed consent forms were stored separately from the audiotapes, written material and transcripts. All materials were kept in locked cupboards when not in use and were accessible only to the researcher. Audiotapes, written material, and transcripts will be kept for seven years (University of Alberta Research Guidelines, 1992). Consent forms identifying the participants were stored separately from the data and will be destroyed after five years.

**Anonymity**

The identity of the participants and their involvement in this study was known only to the researcher. Data collected during the study including stories, quotes, and ideas were kept free of identifying characteristics. A number assigned to each participant was used to identify the participants on audio tapes, transcriptions, and fieldnotes. In the final report, participants were assigned numbers. Other information given by participants during the interviews which may provide identification, such as names of family members, doctors or hospitals, was revised using fictitious names and/or initials. Participants were made aware that the material in the study may be used in teaching, writing for publication, and possibly secondary analysis, but that no names would be used. If secondary analysis seems appropriate, ethical approval will be sought for any new proposal.

**Risks and Benefits**

There was no monetary gain or other benefit to the participants in this study. It is hoped that participation in this study provided an opportunity for the participant to help others understand the experience of having an eating disorder during pregnancy. Participation in the study involved a commitment of a minimum of one interview of approximately one hour each in length. All information was kept confidential and it was left up to the participant to decide whether or not to discuss the interviews with significant others, including parents or peers.

All participants expressed an interest in receiving a summary of the study results. Participants filled out the lower portion of the consent form (Appendix D) so that the researcher can forward study findings upon completion and acceptance of the research study by the thesis committee members.

# CHAPTER IV

## FINDINGS

*If you bring forth what is within you, what you you bring forth will save you. If you do not bring forth what is within you, what you do not bring forth will destroy you.*
*Jesus –The Gnostic Gospels*

The purpose in this research study was to explore and describe the experience for women of having an eating disorder during their pregnancy. Once data analysis began, it became apparent that in addition to describing and exploring the phenomenon of eating disorders during pregnancy, a beginning process was unfolding. Initially ethnographic analysis was used but once a process was identified, a grounded theory approach to data analysis was pursued in examining the core category and its relationship to other aspects of the data. The process of **"protecting"** was identified as the core category emerging from the data. "Protecting" is a basic social process as it occurs over time and theoretically accounts for variation in behaviour which continues irrespective of place (Glaser, 1978).

The text includes descriptions of the participants' ideas and verbatim quotes in order to capture the essence of their perspectives. Fictitious names were given to each participant: Abby, Bonnie, Carol, Donna, Eva, Francis, Ginny, Hope, Ina, Jessica, Karen, and Lisa. The data are identified using the notation (Abby, 1.1), which identifies the participant by her fictitious name, participant number, and interview number. These real stories from courageous women directly affected by eating disorders during their pregnancy offer knowledge and wisdom which can only be acquired by personal experience.

*Experience is not what happens to a man.*
*It is what a man does with what happens to him.*
*Aldous Huxley*

In this chapter, a summary of womens' experiences of having an eating disorder during their pregnancy will be presented. Following this, the findings of this research related to the basic social process of protecting will be presented in both text and in a schematic model (see Figure 1). Although the findings will be presented in a linear fashion to ensure clarity, it is important to note that the process of protecting may be viewed as a complex interaction between interrelated antecedent conditions, action/ineraction strategies, influencing factors, and consequences. Thus, antecedent conditions to the core category of protecting will be presented, followed by action/interaction strategies and influencing factors used to manage the phenomenon of eating disorders during pregnancy. Next, the consequences of the influencing factors will be presented.

## Protecting: A Basic Social Process

### Overview

The main theme emerging from the data centres around the way in which women who have an eating disorder during pregnancy protect either their own self-image as a thin person or the health of their baby, or a combination of the two. The basic social process of "protecting" has antecedent conditions, action/interaction strategies, and consequences or outcomes. Protection exists on a continuum between two competing motivators: (i) the health of the baby and (ii) the pursuit of thinness.

Where a woman places herself on this continuum is contingent upon how she perceives the threat to her self-image as a thin person versus the risk to the health of the baby. This personal risk assessment influences the depth to which women seek reassurance from others and whether they engage in protective behaviours of self-image and/or the health of their unborn baby. Self reassurance occurs throughout the pregnancy, and varies in intent depending upon where the woman lies upon the protecting continuum.

A woman's ability to protect is also influenced by identified factors which are enmeshed within the process and are both internal and external in nature. These factors include emotions, actions, and external factors. The emotions include fear, uncertainty, guilt, and concerns about body image. These emotions elicited the action or the motivation to alter the participants behaviours. Successful action was dependent upon the degree of perceived social support. Another factor was the transition to parenthood which also had to be negotiated within the eating disorder framework. The influencing factors' interaction with the

process of protecting focuses on the strategy of assessment of perceived risk to the health of the baby versus the perceived threat to self-image as a thin person.

The movement towards one or the other competing motivators on the continuum is also dependent upon how the woman interprets and internalizes stressors in her life. If the stressor is perceived as a threat to her self-image, she will move more towards protecting her self-image whereas if the stressor is perceived as a risk to the baby, she will move more towards protecting baby.

How a woman negotiates nutrition throughout her pregnancy is also of importance to understanding this process. A woman utilizes various coping strategies to manage her eating disorder during her pregnancy. These coping strategies can take both healthy and unhealthy directions. If she is in an emotional state which is that of protecting baby, she will seek out healthy strategies for maintaining optimal nutritional status. This involves identifying problematic areas, nutritional education and guidance, and behaviour management. However, if she is in an emotional state, that of protecting her self-image--or the pursuit of thinness--she will utilize unhealthy strategies, namely food restriction, with the intent to be thin.

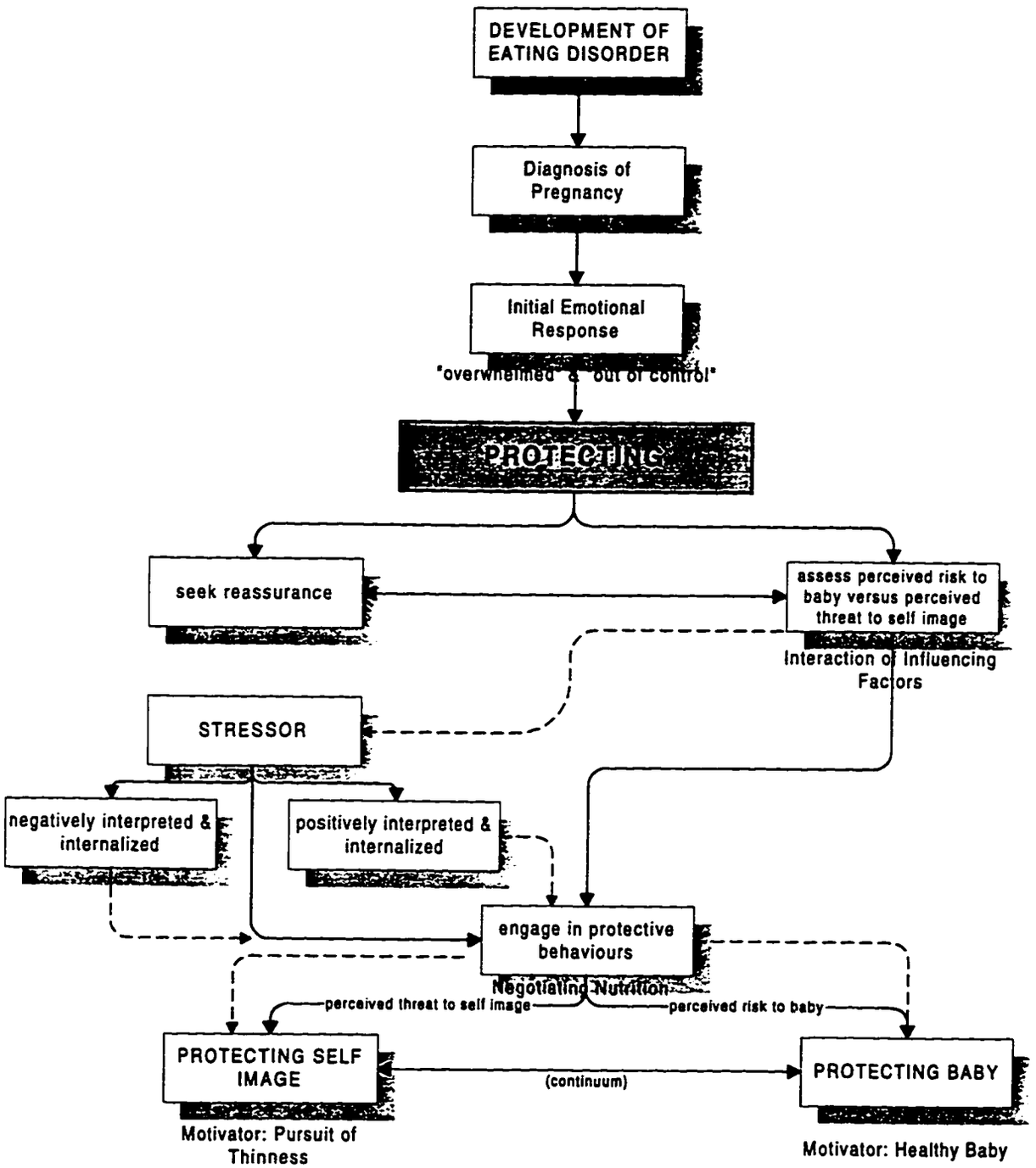


FIGURE 1: THE PROCESS OF PROTECTING SELF/PROTECTING BABY

## Antecedent Conditions

Antecedent conditions are defined as "events or incidents that lead to the occurrence or development of a phenomena" (Strauss & Corbin, 1990, p. 100). In these findings, the development of an eating disorder, the diagnosis of pregnancy, and the initial emotional response that accompanies this diagnosis, lead to the occurrence of the core category of protecting. These antecedent conditions will now be explored.

### The Development of an Eating Disorder

Anorexia nervosa and bulimia nervosa primarily affect women who are in the childbearing years. The development of the eating disorder usually precedes pregnancy and often begins in the early adolescent years. For all of the women who participated in this research study, their eating disorder long preceded their pregnancy. A brief exploration of the development of the eating disorder for these participants is important in order to fully understand the dynamics and complex history and issues which the eating disorder brings to the pregnancy. The predisposing and precipitating factors leading to the diagnosis of anorexia nervosa or bulimia nervosa for the participants in this study will be explored. These factors can also be viewed as a schematic model (see Figure 2).

*We do not 'come into' this world;*
*we come out of it, as leaves from a tree.*
*As the ocean 'waves', the universe 'peoples'.*
*Every individual is an expression of the*
*whole realm of nature,*
*a unique action of the total universe.*
*Alan Watts*

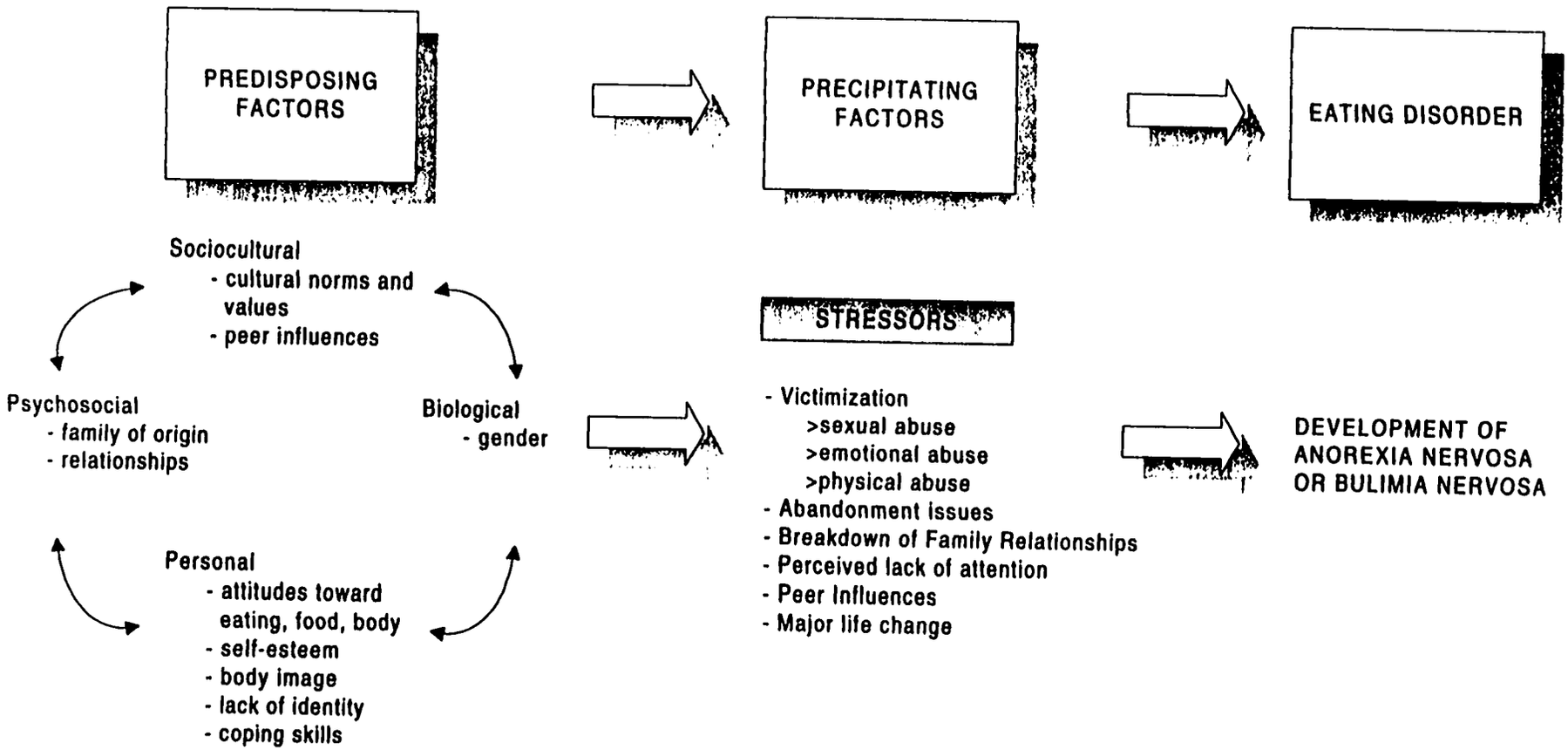


FIGURE 2: DEVELOPMENT OF AN EATING DISORDER

## Predisposing Factors

For the participants in this study, the predisposing factors were sociocultural, psychosocial, biological, and personal in nature. All these factors were interrelated and all contributed to the complexity of the developing eating disorder.

### Sociocultural Factors

In Western culture, the values reflect a focus on thinner and more angular shapes for women and the preoccupation with youth. These influence societal norms in relation to fitness, fashion, and dieting and the changing roles of women.

These sociocultural norms created real pressures for all of the participants who shared their experience in terms of pressures to be thin and their response to this through dieting. Hope, Ina and Abby illustrate both the trigger and the response. They reflect a common experience identified by participants:

> As a child the word 'diet' was commonly used in my house. My mother was always on one diet or another and seemed obsessed with my weight. I was an average to small-sized person, but I was conditioned to believe that being very slim was important for women--an ideal towards which I felt compelled to direct my efforts. Dieting became the norm for me. I have never known what it is like to not be on a diet. (Hope, 8.1)

> I didn't start to diet until I entered high school. At that time my body was changing and developing, and I started to put on more weight. My group of friends expanded and everyone seemed to be preoccupied with being slim. A few times I limited myself to a dangerously low caloric intake, and my weight dropped rapidly. I remember everyone commenting on how skinny I looked and it made me feel sort of happy to be noticed and thought of as slim. (Ina, 9.1).

> Well, it started when I was about 15 years old and I just decided one day to go on a diet...so I did. I didn't eat anything for two days and then the weight...you lose a lot of water at first so it looks really good on the scale to you. And then I just kept not eating, and exercising, and not eating and then I lost probably...well, 'til about 80 pounds. (Abby, 1.1).

Dieting was a common experience for all of the participants in this study. The dieting consisted primarily of restricting food intake in varying degrees, from no intake at all to minimal intake. Dieting was perceived as a successful method through which to pursue thinness since it produced quick results.

For three of the participants, the pursuit of thinness was influenced by their desire to remain young, fit, and fashionable.

> I didn't see a fat person right off the bat. I definitely developed that afterwards...where I'd look in the mirror and I'd just be so repulsed with myself that, you know, I thought I was obese. At first it was more like the feeling of being uncomfortable. You know, naturally growing out of a kid pair of jeans into adolescent sized jeans and the feeling of it...hm, hm, these are snub or these are a bit tight or, you know, the legs aren't so skinny the way they used to be when you were a kid and it was the feeling of things...that started to drive me....I just didn't want to get bigger....Occasionally I would get,like "Christmas is coming and I've got to get into this dress and got to be ultra thin for that". (Donna, 4.1).

> I loved being in a body that was thin. I remember being the best at sports. I was even better than all of the boys. I was this jock and everyone knew who I was. Things really changed for me though when I started to develop...you know, get breasts and stuff. People changed around me, well both boys and girls and all of a sudden I wasn't seen as such a jock anymore. I was growing up and along with that came breasts and hips, and...all I wanted was to be thin again. Somehow I saw my changing body as a hindrance to that goal. I guess I started restricting what I was eating way back then. My identity was changing from that of jock to that of being thin and well, I guess being attractive to boys. (Jessica, 10.1).

> I have always been a fashion plate. I remember never really being that great at anything, except for maybe dressing up. I mean I was capable of doing almost anything, like getting good grades and sports and stuff, but I was never the best. My parents had money though, so I learned early on that I could pretty well get anything that I wanted...and soon enough it was clothes that I wanted. I wanted to look just like the models in the magazines. I even did up a poster when I was in school, putting together all of the looks that I wanted to get...and I achieved all those looks. Being able to fit into all of the clothes meant having to be really skinny...I achieved that too. (Ina, 9.1).

The sociocultural norms were reinforced for the participants as they continued their quest for thinness. Two participants recall the positive reinforcement they received from their losing weight:

> Um...when I started to lose weight people are 'Oh, wow! Do you ever look good!' as we all know. (Bonnie, 2.1).

> When I started losing weight, everyone commented on how beautiful I was--just like a model. All of a sudden I had these cheekbones that everyone commented on, and I could wear all of these tight fitting clothes that were smaller sizes than what the other girls had to wear. I liked that--it made me feel special. (Carol, 3.1).

One participant recalls the attention that she received from family and friends as that of envy:

> Everybody always was very envious of me....because I was always so slim...but that's not how I saw myself....I certainly didn't feel good about myself. (Eva, 5.1)

The reinforcement that many of the participants received changed from positive to negative in that soon others were commenting that they were too thin as opposed to looking good. This reinforcement was not intended to fuel the eating disorder or the pursuit for thinness. However, the comments were interpreted by the recipient as being given attention, and the disordered eating and accompanying behaviours continued:

> And then as you get thinner they start to kind of 'Oooh, you're kind of getting thin.' Friends didn't really say too much until I got really really thin because I guess being with me all the time they never really thought too much about it. So through high school I used to get comments and from the phys. ed. teacher.'Bonnie, you have to use a mat because we don't want to hear your bones clicking on the floor', but nobody ever encouraged me to go for help. (Bonnie, 2.1).

> Then even when I lost weight people would say that I was too skinny but I didn't believe them....I thought they were making it up. And I thought that....that something was wrong with everybody. and they were on my case all the time....Everybody was telling me that what I was doing was not good. (Abby, 1.1).

> I got away with it really easy as a young, young kid but at about 17 or 18 and I was still not getting bigger, in fact I was losing weight on top of everything people were starting to say, 'Gee, you're awfully thin!' or 'You don't eat very much.'....It was like concern. Cautious concern....people would notice my effort so I knew I was getting there and that 'Great I can do this' so I can do this even more. Like it was weird! Just...I guess the more concern the thinner I would become. The more people drew attention to it, the more obsessive I got about it. I had to lose even more weight. I was really thin....it was kinda like 'Ha Ha!' a game. I don't know, maybe that's how a person...I dealt with it. I made a game out of it so it didn't seem as bad as it was or as dangerous as it was but I just kinda, you know, every day I could, you know, pull it over on somebody. So, right on--it was another point for me. (Donna, 4.1).

For these participants, thinness was equated with control, success, goodness, power, and beauty. Participants identified these attributes as societal values which influenced their desire to be thin.

**Psychosocial Factors**

The psychosocial factors included such things as family-of-origin dynamics and other relationships, including intimate relationships. Many participants commented on their families-of-origin and the difficulties

that the families had in relation to dealing with stress, managing and resolving conflict, and expressing emotions. Although the researcher's question focused on family dynamics, the majority of the participants talked mainly about their relationships with their mothers:

> ...and there were some underlying issues that, at the time, I didn't realize that were going on but I do now as an adult. Which is one, I have scoliosis....And the only time my mother had time for me was at that time period because I was sick. Other than that she was working outside the home. So...it became an issue of...well, that's kind of how I had her attention. (Bonnie, 2.1).

Once Bonnie was diagnosed with an eating disorder, she described the responses to her diagnosis as denial, from both herself and her mother.

> Yeah, but I didn't really want to admit it to myself, plus, my mother wouldn't admit that I had the problem so...it was something that I would deal with.

Denial of the developing eating disorder was a common experience for many of the participants. There was a shared belief that it was others who had the problem:

> I just did not eat and I got away with it really easy. Like, nobody really said anything, or noticed or, you know, and then...a little bit later on, a couple of years later I did see TV programs where they addressed the issue and I thought 'That's kinda like me' but I still didn't associate it with the name or anything...I just thought 'Well, I don't eat cause I don't want to get fat'. (Donna, 4.1).

> Sometimes people would tell me that I was getting too thin and that maybe I had a problem. I remember smiling inside thinking 'Yaah, you're the one with the problem'. I really felt that way....I mean, according to society I was it! You know, thin. (Ina, 9.1).

Two participants describe growing up not wanting to be like their mothers:

> I think where it kind of stems from is that my mom is overweight and my sister is now...and I always...even going back to high school, Grade 10 seems to stick in my mind...I was very cautious of my weight and at that time I was by no means fat, probably quite slim....I remember even from a younger age thinking I don't want to be like my mom. I don't want to be as big as my mom and...looking at it now...she wasn't probably that big but she was a very dominant woman and she was the one that was the dominant role in the family. You know, it was sort of a threatening thing. (Eva, 5.1).

> I remember hating my mother. Oh man, that sounds so awful now. The thought of being like her repulsed me and I wanted to deny that she was my mother. The funny thing is she was really a beautiful woman, I am not sure why I felt so strongly about her back then. Maybe because she was so traditional, and I guess that meant being passive to me back then. She really wasn't passive at all. (Jessica, 10.1).

One participant describes her family as being strict and rigid:

> The anorexia was replaced by bulimia as I began to lose faith in the undying strength and correctness of my parents' outlook on life, the way they raised me. Let's just say that I was a late bloomer, and, like many adolescents, I began to rebel against my strict upbringing, an upbringing in which I increasingly saw myself as someone who had moulded myself to their needs. I began to believe that there were holes in the armour of my upbringing--that in spite of my parents' good intentions, I was not loved for myself and who I was as a person, but I was approved of as long as I fulfilled their need to display a well-behaved, well brought up child....My parents weren't bad parents by any means. They were doing the best they could with what they had, and they happened to be perfectionists who demanded a lot of themselves...they demanded the same discipline of me. I had to be a good kid and for my family that meant being obedient, quiet, and helpful. Never rock the boat, that's me. (Ginny, 7.1).

The idea of having to be the "perfect child" was not exclusive to Ginny. In addition, participants believed that they were unable to live up to their parents expectations, that they were never quite good enough no matter how hard they tried:

> I am the youngest of three girls. Many people think that that may be an advantage but I can assure you it wasn't. My sisters were both very successful at anything that they did, and the same standards existed for me as well. No, actually I was expected to achieve even more. It is kind of like no matter what I did, it was never good enough. I was a straight A student, captain of the basketball team, and dated all the most popular boys but it still wasn't enough. I began feeling like I was living my life for my parents and not for me. Even if I did it all perfectly...well, you know, I could have done it better. (Carol, 3.1).

> I really love my family but sometimes being a part of that 'fantasy family' was really difficult. I can understand maintaining an image for the rest of the world but it became really difficult to keep up the game within the walls of our own house. Sometimes I just felt like screaming at my parents. I mean, what is wrong with making a mistake or two in life. Not in my house...the sense of failure was huge. I don't remember my parents ever telling me that 'you've done a great job' and 'we're proud of you'. It's no wonder I can never please myself--I've had years of practice of being a disappointment to everyone. (Francis, 6.1).

Other significant relationships also influenced the participants eating disorders. One participant describes the influence of breaking up with a boyfriend:

> My eating disorder didn't develop until I went to university. Well, perhaps it started a bit before then but anyways....I experienced a very painful breakup with my first love, and it took me a long time to recover. My self-esteem was very low and my whole world felt out of control. In my pain, the only thing I seemed to be able to control was my food intake....The only catch was that I felt guilty and ashamed....During the final three years of university, I shut myself off from relationships and concentrated on my eating disorder. (Carol, 3.1)

Donna describes how her eating disorder affected her relationship with her husband:

> It's awful! Wrecked my marriage inadvertently, I think. Because I became...it became more important than my marriage at one point. (Donna, 4.1).

All of the participants at one point during their interview commented on the effects of disordered eating on their families and friends, as well as the reverse. Clearly the relationships, family or otherwise, in the participants' lives were influential in the development of, and subsequently influenced by, the participants' eating disorders.

**Biological Factors**

Gender is the strongest biological determinant for susceptibility to disordered eating, with women outnumbering men by at least a ten to one ratio. The participants in this study, all women, felt conditioned to be "ideal women". Several participants felt that they learned how to be women from their mothers--the majority of whom suffered from a weight preoccupation which was passed on to their daughters.

The adherence to traditional views of femininity--passivity, compliance, dependence, self-sacrifice--puts women at risk for eating disorders. There is something happening in the experience of girls and women today that is very distressing to their sense of personhood, a sentiment expressed by several of the participants.

**Personal Factors**

The personal factors influencing the development of an eating disorder are complex and difficult to adequately explore given their intricate nature. As the exploration of personal factors are key to understanding the participants on a deeper level and hence the relationship of the eating disorder to pregnancy, they will be addressed. It is important to note that these personal factors are intricately related to the sociocultural, psychosocial, and biological factors previously addressed.

There are a number of personal factors that present as predisposing factors to the development of an eating disorder. Some of these factors include: personal attitudes toward eating, food, and body; self-esteem; body image; lack of identity; and coping skills. Due to the interrelatedness of the above factors, they will not be presented individually, but rather as a cumulative experience.

Body image plays a large role in the development of an eating disorder. For all of the participants, there were issues of body image which were influenced by how the participants perceived they were received by others, and also by how they perceived themselves.

Bonnie's body image was directly influenced by the diagnosis of scoliosis of her spine at a young age:

> I have scoliosis...which is curved spine...and checks on my spine...that was very intimidating, very upsetting. I found it very hard. I was labelled as a crippled child. I was always with a group of at least four men in the room, poking and prodding and looking at my back and here I was a twelve year old...thirteen year old kid when this all started happening...which I found, I guess, degrading to a certain extent because...they would talk amongst themselves but never really to me and here I am just a kid and that was hard. (Bonnie, 2.1).

Bonnie continued to talk about her scoliosis, how it affected her, and how she coped:

> I felt everybody had control of my life and I didn't have any control. I was a very passive kid...I let everybody walk all over me...and so I just decided that I was going to control my food. I don't think there was anything that consciously came and clicked one day and said 'control your food', it just became an obsession. (Bonnie, 2.1).

Carol and Hope also described their experience with self-esteem, body image, lack of identity, and other personal factors:

> I have never liked myself but it's hard for me to explain to you why I feel that way. I mean, I know that I am not grotesque or anything, and I am smart I guess, but...there is just something inside me that makes me feel not quite right. I can look at myself and even if I am dressed to the nine's, I still feel like I'm not right. I can fix as many things as I want on the outside, but the inside remains empty. How can I like myself if I don't even know who I am? (Carol, 3.1).

> I cry all the time. Someone asked me the other day why I can't just snap out of it and pull myself together. I would love to be able to do that but I have no idea of where to begin. I mean...counsellors have tried to help me...how would you say it? I guess 'find myself' but I fail at even this. I feel a bit like a puzzle, a really complex one, but the picture is blurry, I am not even sure if it is complete exactly...and I am of the belief that I must be missing a few pieces. I have been told to have faith. I just don't think that it is that simple. It is rather comical in a sense....in a sick sadistic sort of way. (Hope, 8.1).

Although most of the participants did not comment on it directly, their eating disorders, although unhealthy in nature, were actually a method of coping for them. Their eating practices allowed them to cope with the perceived stresses and the feeling of loss of control they were experiencing in their lives. Bonnie described the process in the following way:

> When I can't control anything around me, when I...well, I didn't know how to cope with feelings so...the only way I knew how to cope was through learning how to do this disorder and now I'm learning and I know better methods of coping which is looking for support before things get out of hand....So it seemed every time that I had a stressful relationship or...anything that was really hard on me emotionally usually set it off....It seems to come out when I'm more stressed out. (Bonnie, 2.1).

## Precipitating Factors

Precipitating factors are those factors which are stressful events which serve as an additional trigger towards the diagnosis of eating disorder. For the participants in this study, the precipitating factors, or stressors, included such things as: victimization; abandonment; breakdown of family relationships; perceived lack of attention; peer influences; and major life changes.

**Victimization**

Victimization in the form of sexual abuse, physical abuse, or emotional abuse, was a common experience for the participants in this study. Of the ten primary participants, six reported a history of sexual abuse which also frequently involved physical abuse as well, three reported histories of physical abuse while one participant did not acknowledge any abuse in her history. The participants were not asked about abuse when being interviewed, rather the information emerged when the development of the eating disorder was explored during the interview. None of the participants identified histories of emotional abuse, however given that several of the participants expressed histories of sexual and physical abuse, it is probable that emotional abuse is inherent within those experiences.

Several participants shared their experience of sexual abuse. For some this early childhood experience led to a life of sexual promiscuity, often from a very early age:

> I had been sexually abused all through my younger years. Five years old, six years old, seven years old. And then I was sexually abused again at the age of nine. And then I kind of...I've been sexually active from probably the age of twelve on. (Bonnie, 2.1).

> I was molested when I was younger. And it was an older man who was bigger....When I was about eight....and then it kinda continued until I was fifteen....It was supposed to be a friend of the family. (Eva, 5.1).

Eva continued with her emotional story and how it influenced her eating disorder:

> I didn't want to be...like a woman. Like I didn't want to have breasts, to have hips...because then that would make him notice it that much more...because he would always make comments about it which always made me feel very uncomfortable. (Eva, 5.1).

Eva's shared experience demonstrates a woman who has disassociated herself from parts of her body. She identified her breasts, hips, and body in terms of "it". Others also unconsciously referred to their bodies in such a depersonalized way. The denial of their bodies was a method for protecting themselves:

> My body wasn't mine anymore. Actually I am not sure if it really ever has been mine. When he used to touch me I kept telling myself--but not outloud so that he could hear me--just on the inside that he wasn't really touching me because those parts didn't belong

> to me. I hated when they started to get bigger....It was like my body was betraying me, making me more accessible to him. He used to tell me how much he loved them and how it was better when they were bigger. I hated him, I hated them, and I hated me. My developing, like getting breasts and hips and stuff was like...well, it was like a final surrender to him...like the body was his now and not mine because somehow it felt like they were growing and reaching out to them. God that's sick. I wanted him to hate me the way I hated myself. (Hope, 8.1).

For the women with histories of sexual abuse, other similarities existed such as the perpetrator was someone known to them and someone that they initially trusted. The experience of sexual abuse also coincided with the development of the eating disorder.

The experience of physical abuse was also shared by some of the participants. Similar to the experience of the sexual abuse survivors, their stories also reflect feelings of betrayal and disassociation with themselves:

> When he hit me I just kept telling myself that it doesn't matter because he doesn't have the power to hurt me. My body told a different story when the beating was over but when it was happening it was like...well, I couldn't feel a thing. Although on the inside I couldn't believe that he would do this to me again...you see he used to promise stuff like it would never happen again....Sometimes I would start bleeding and it was really weird 'cause I would see the blood and think 'Gee, look, there's some blood'...it took me a little while to figure out it was mine. (Jessica, 10.1).

When exploring the history of abuse with the participants, the interviews became intensely emotional for both the participant and the researcher. It was, for many, the first time they had shared their experiences and confided in someone who would listen without laying blame or placing judgement. For them, the wounds were just beginning to heal. For others who had searched for meaning in their experiences and reached a place of healing, exploring their past was a chance to reward and acknowledge themselves for the amount of emotional recovery that had taken place. For all, the journey to a place of peace continues, the road longer for some than others.

**Abandonment and Other Issues**

Abandonment issues are closely related to other precipitating factors such as the breakdown of family relationships and perceived lack of attention. For this reason, they will be presented together as they exist in the stories of the participants.

For some participants, feelings of abandonment centered around family dynamics, including the breakdown of family relationships:

> Well, my parents were divorced when I was eight or so...it didn't start when I was only eight years old, it happened later. (Donna, 4.1).

> Anything that was hard on me emotionally usually set it off. My mom's boyfriend leaving us when I was fourteen...that really set me off into another downslide. That's how it's been. That and the emotional...not being nurtured at home. Not having a support system at home definitely made a difference. (Bonnie, 2.1).

> My parents split up when I was quite young. I know that it was a good thing but it still affected me when I was young. My father was an alcoholic and even though life was pretty frantic at times, at least it was consistently frantic. When they split up I felt like everything I had known and was used to, changed. It may have changed ultimately for the better, but it still changed. Something was missing--my dad, my family as I had known it, was gone. I was really alone now. (Jessica, 10.1).

There were also feelings of abandonment when one had to change counsellors or therapists. For one participant, this experience was traumatic enough to adversely affect the progress that she had made:

> So the first time I went to the dietician I was about fifteen years old and unfortunately she left. And when she left, I lost my weight again. (Bonnie, 2.1).

Several of the participants in this study felt as though the stressors in their lives that centered around abandonment reinforced for them that they were of little value. They believed their family breakups to be a direct reflection of their own insignificance and lack of value within that family. This led to behaviours that supported the belief that they were worthless.

**Major Life Changes**

Changes in one's life can be perceived as stressful events and may precipitate an eating disorder. These major life changes can take many different forms. The changes may be as minor as changing homes to as major as changing cities. The significance of the change is all a matter of how the particular change was perceived by the participant.

For one participant, it was a number of changes within her early school experience that were stressful because they led her to feeling unaccepted:

> I guess it started in grade two that I never felt accepted....I was held back...so a completely new group of people....No one accepted me and then I was with that same group right up until grade six, and then I went into a different school in grade seven but still saw a lot of those same people. And then I changed again in grade eight into a different school again....But again even in grade eight I was back into another school again not feeling accepted. (Eva, 5.1).

For another participant, it was going away to school that was a precipitating factor:

> I moved away from home at the age of seventeen to enter nursing school. I found friends with whom I developed a sense of trust and belonging. This belonging, however, was in the form of being thin. I definitely wanted to belong...this was my ticket. (Ginny, 7.1).

The predisposing and precipitating factors identified by the participants appear to lead toward defensive behaviours which manifest themselves in eating and the preoccupation with weight, body shape, and food. The defensive behaviours direct the participant to an eating disorder. The process is cyclical in nature in that once an eating disorder is established, a vicious circle of denial and restriction begins. The eating disorder takes over and begins to consume that individuals life, reinforced by both the predisposing and precipitating factors.

Abby sums up the experience of developing an eating disorder:

> I think it's just something that gradually happens over time. It's not really linked to just one incident...I can think of a whole bunch of little reasons....It's like being in a concentration camp. It's because when you don't eat, then your body starts doing strange things-like you can't sleep. And you can't sleep then you can't think. And so when you can't think....and then when you exercise too much it really starts doing things to your brain. So, no sleeping, no eating, too much exercise, and not thinking clearly...you kind of brainwash yourself. It just goes round and round, stopping only to let you off so that you eat to survive--then you get back on again. (Abby, 1.1).

## Diagnosis of Pregnancy

The diagnosis of pregnancy came as a surprise to all of the ten participants. Five of the participants had been trying to conceive but did not know whether they would be successful given that they had absent or irregular menstrual cycles. The other five participants did not plan the pregnancy. This is in reference to the most recent pregnancy for those multiparous participants. Previous pregnancies for three of these participants were unplanned and for the remaining two participants, this was their first pregnancy which was planned. Therefore, one can conclude that, for the majority of the participants, their pregnancies were unexpected.

One participant describes the experience of trying to get pregnant with her first child:

> Yeah, the first time...Oh, we tried for a long time, a year at least and then we just said 'forget it' and then as things started going better for me, like, I quit exercising as much and I started eating better and then we weren't trying at all, and I decided that I was going to do my Masters in Education and I mailed my application and I went across the street to the doctor's and she says 'Hey, you're pregnant'. (Abby, 1.1).

When Abby and her husband were wanting to conceive their second child, they had more immediate success due to Abby's change in behaviours:

> I was going to try a little bit...to try to do something. And then this time we planned it...and so a little bit before I started eating better and using the little cards and leaving them in the pockets and...the first time we decided to try it just worked. (Abby, 1.1).

For Abby, this "game-playing" was helpful to her during this time (pre-pregnancy) as well as during her pregnancy:

> ...I try different things...the food chart or else she gave me little cards to move into different pockets. Sometimes you play games with yourself to see if it can help a little bit....it was pretty good. (Abby, 1.1).

The "little cards" that Abby refers to are cards that were given to her by her dietician to remind her that she needs to eat, and also what she needs to eat. The idea behind this is to keep the cards in your pocket and as you use them (ie: eat) then you transfer them to the other pocket.

The suspicion of pregnancy was not common to all of the participants. For the five participants who planned their pregnancy, they felt more attuned to the signs and symptoms of pregnancy, therefore suspecting conception whereas the five participants who did not plan the pregnancy, sought medical care for generally not feeling well.

For those participants who suspected pregnancy, it was symptoms such as breast tenderness, nausea, and just "knowing" that lead them to confirm their suspicions:

> I knew that I was pregnant for some reason. I can't really explain it. I guess it is because I wanted it so bad....I was kinda scared though, thinking that maybe I had talked myself into it...but you know when you just get this gut feeling. I just knew it....My breasts hurt too, I mean they were really tender. I took that as a good sign. (Jessica, 10.1).

> I woke up feeling sick for a couple of mornings, like I had to throw up. It wasn't normal for me to be feeling that way. I mean, I knew that my body was pretty out of whack but I just knew that it shouldn't be doing that....My breasts were really sensitive too. I hated that because it reminded me that they were there. I have never really liked my breasts and now here they were, making nuisances out of themselves....It was my husband who suggested maybe I was pregnant. Once he said that I just knew. (Carol, 3.1).

For those participants who did not plan their pregnancy, some of the reasons that lead them to seek medical attention were feelings of general unwellness, feeling overly tired, and unexplained bloating and nausea. Although they were not aware of it at the time, it was the sensation of early fetal movement that they felt but could not identify with:

> It is hard to explain, but I felt unusually bloated and also nauseous. A lot of the time I feel bloated but this was different...and usually I don't feel sick like that. It was different, but I didn't know how to explain it. I couldn't believe that it was because I was pregnant. That seems so silly to say now because just hearing myself talk, I guess it was clear all along. (Eva, 5.1).

Two participants also report noticing that their bodies were appearing even "larger" to them, despite the restriction of food:

> God, I was so out of touch with what was really happening to me. I was really scared that I had overdone it this time, gotten really out control and now my body was rebelling against me by doing all sorts of weird stuff. Looking back now I realize that it was the baby moving but back then, God...I was scared to death. My guts were like...moving...and I felt huge, even though I hadn't eaten a thing. I thought it was something I had eaten so I wasn't about to eat anything else. It kept happening though so finally I went to see somebody. (Ina, 9.1).

> I was exhausted and felt horrible. I just assumed I had a really long case of the flu. I never would have guessed I was pregnant. I remember thinking that things just didn't add up. I mean, I wasn't eating anything at all and yet my body was getting bigger. It has happened to me before where like, you hit this kind of plateau and you don't lose any more weight...but that only lasts for like a week or something and then you lose a whole bunch at once. That didn't happen this time so I knew that something had to be up. I went to the Doctor because I thought yet another thing was wrong with me. (Ginny, 7.1).

None of the participants report absent menstruation as a sign of their pregnancy. One of the participants reported experiencing a false pregnancy occurring after the birth of her last child. There were complex issues surrounding this experience, both psychological and physical, but she describes feeling convinced that she was, indeed pregnant:

> I had a false pregnancy where I thought I was pregnant and I went through if for...I went through a couple of months. I bet you four months I convinced myself that I was pregnant. I know I can't get pregnant but I had convinced myself. I went through tests, I went through ultrasound...I was convinced I was pregnant....I wanted to be pregnant...because that was the time that our relationship wasn't going very well. It was a feeling of acceptance...if I was pregnant and I felt I was accepted again....It was like thinking of the pregnancy...that's when I started to eat more to make it appear that I was gaining...and that was really hard for me to finally say, 'OK, you're not pregnant, you can't get pregnant'. You know, going through all the doctors and tests and things...and I'm thinking everyone else is crazy and I'm the one who is crazy. (Eva, 5.1).

Eva's story of experiencing a false pregnancy is unique to the study. It does, however, lead one to question how the diagnosis of pregnancy is received for those that are indeed pregnant. For Eva, being pregnant meant acceptance from significant others. Pregnancy was a desired condition. For all of the

participants in this study, their pregnancies have been considered positive in that the outcome was a healthy baby. The road to this outcome, however, is not always positive.

## Initial Emotional Response

The initial emotional response to the diagnosis of pregnancy varied for the participants. However, there were two common responses to the discovery of their pregnancy: feelings of being "overwhelmed" and "out of control".

Feelings of being overwhelmed with the discovery of being pregnant were common to all of the participants in this study. These feelings were also accompanied by other intense maternal emotions such as shock, fear, surprise, and elation:

> Oh, I couldn't believe it...because I wanted to have a baby for so long...and then finally I did...it was the first five weeks or six weeks you don't feel things really...like the baby doesn't move and you might feel a bit different, like more tired....I never felt...like this before. (Abby, 1.1).

> I was under the complete impression that I couldn't conceive because I was so thin and....for the whole year and a half I hadn't menstruated. I thought, 'well, I'll never get pregnant' and low and behold I ovulated. The doctor thought it was a miracle....I felt scared. I felt stuck 'cause I thought, 'Oh no', this is now a decision of not just my life but of this little beings life and I had to make a lot of decisions in a kind of short period of time, being on medication, being 92 pounds, not being married, knowing that I had a history of depression, knowing that I had a history of anorexia....It was very difficult. And the first three months were hell. (Bonnie, 2.1).

> I was shocked when I first found out that I was pregnant. I felt this flood of emotion come over me. It was overwhelming. I remember just sitting there in the Doctors office balling. They were tears of joy but I have to admit I was scared. I mean...it wasn't just about me anymore. (Francis, 6.1).

Several of the participants expressed intense feelings of being "out of control". For some of the participants, this also involved feelings of powerlessness and violation:

> God, I had such mixed emotions when I was told I was pregnant. This sounds so selfish but I thought about how I was going to be able to get away with my eating disorder if everyone knew that I was pregnant. No one knew about my eating disorder but I knew that as soon as people found out about my pregnancy, people would be watching to make sure I took care of myself. I was panicked. I just couldn't imagine allowing myself to lose control over my eating. Everyone would be telling me what I should and shouldn't be eating....I didn't think I could handle that. (Ina, 9.1).

> Once again I didn't feel like my body was mine anymore. When I was sexually abused I felt that way....it was weird feeling violated...it was like this baby was going to take over my body without my control. When he used to take over my body, I just let it go because I could remove myself from it...but I couldn't do that with a baby....This baby was inside me, needing me, and I was no longer in control. (Hope, 8.1).

The initial emotional response to the diagnosis of pregnancy left some participants feeling like they needed to make decisions about the pregnancy itself. One participant, Bonnie, experienced a range of intense emotions when she thought about some of her choices:

> I guess it was...it was more because...this may sound awful but I couldn't have an abortion only because I didn't want to feel guilty about one more thing in my life. I didn't want that to be another thing that I would go to my grave with...and I thought if I could give this baby a chance that maybe things would...I don't know...be better somehow, I don't know. At first having that decision and knowing that I was going to be pregnant because of that made me feel bad in some ways and in other ways I felt kind of strong because I...no one else had that control but me. I was able to say, 'Yes, I'm going to keep this baby' or 'No, I'm not going to'. (Bonnie, 2.1).

One of the factors which was influential in Bonnie choosing to remain pregnant was her support system. The idea of having a support system was also reported to be of importance to other participants as well:

> People would have been understanding and supportive either way which helped a great deal because I don't think I could have made that decision knowing that I didn't have any support. That was very important. (Bonnie, 2.1).

> Gosh, he was beside me every step of the way...even when I pretended that I didn't need him, he stayed with me. I don't think I could have done it without him. (Carol, 3.1).

The development of the eating disorder, the diagnosis of pregnancy, and the initial emotional response to the diagnosis are all antecedent conditions to the process of protecting: a woman protecting her self-image as a thin person and protecting the health of the baby during her childbearing experience. These precede the action/interaction strategies which were used by the participants.

## Action/Interaction Strategies

Action/interaction strategies are those goal-directed, processual strategies undertaken in response to or in order to manage a phenomenon (Strauss & Corbin, 1990). During the process of protecting, the action/ interaction strategies undertaken by the participants were seeking reassurance and assessing the perceived risks to the baby versus the perceived threat to self- image as a thin person. These strategies were influenced by stressors, or life events, that were experienced by the participants during their pregnancy. The strategies were impacted by influencing factors, the results of which led to the engagement in protective behaviours with negative or positive consequences to either the mother's self-image or the health of the baby as a result of competing needs. The engagement in protective behaviours included the negotiation of nutritional status during pregnancy.

## Seeking Reassurance

After confirming the pregnancy, women in this study immediately sought out reassurance from others. Participants targeted health care professionals as well as other women who had experienced a pregnancy. The majority of the participants did not disclose their eating disorder during their pregnancy, so they were careful about what information they provided to others while they sought out reassurance for their own behaviours and for the progress of the pregnancy.

The participants hoped that they would receive information which would reassure them that their pregnancy was normal and progressing as expected, despite any unhealthy behaviours that they might be undertaking. The women also hoped that they would be reassured that they did not appear too large, or had gained too much weight. They also provided evidence of strategies they used to protect themselves from the need to disclose information on their eating disorder:

> I must have asked ten or twelve times every prenatal visit, 'Are you sure that the baby is OK? How do you know the baby is OK? Has the baby grown?' My list of questions was endless...I couldn't hear it enough that everything was OK. I never stopped there though. I think I phoned every friend that I had that had ever had a baby...I wanted to know that my pregnancy was just like theirs. It made me feel like I had a better chance of having a healthy baby. (Carol, 3.1).

> I read every book that I could on pregnancy so that I would be prepared when I went to see my Doctor. I had a list of questions each visit just to make sure that I knew what was happening. Part of the reason I asked so many questions was also so that he didn't ask me anything. There is no way I was going to let him know about my eating disorder....He kept reassuring me that things were progressing normally, and that's what I needed to hear. I wasn't doing so well, but he said everything was fine, and he's the expert, right? (Ina, 9.1).

> I have such fond memories of that graph...you know, the one where they plot how big the baby is. I wrote down the results every prenatal visit just to remind myself, in writing, that the baby was OK. (Jessica, 10.1).

One participant attempted to find reassurance through finding information in published literature, but due to the lack of available information she found little information that would assist her to learn about her eating disorder during her pregnancy:

> The library wasn't too unfamiliar to me since I had spent four years in University....I was shocked to find no information that was helpful to me. I didn't want to ask anyone else for help because I knew that then people would know about me. I wasn't prepared for that....Although I didn't learn anything about my bulimia and my pregnancy, I did learn more about the signs of a healthy pregnancy. (Ginny, 7.1).

Those participants who had disclosed their eating disorders to their physicians during their pregnancy were able to receive information and reassurance directly from their health care provider. These participants felt some preliminary relief in knowing that their health care provider was aware of some of the issues they were facing:

> Well, with K. [daughter] I think the eating was a little bit easier because I didn't know how it would go and the dietician always wants me to have... eat more...well, I gained...you know you are supposed to gain 25 to 35 pounds and I was in that range...and I am this time again....even though I started out lower, she would rather that I gain 40 pounds or more....I see her every time I go for an appointment. (Abby, 1.1).

> I had a really good relationship with my physician and he knew all about my eating disorder. We agreed that I didn't have to know how much I gained each visit because this was really difficult for me. He respected that, thank God. (Francis, 6.1).

Several participants sought reassurance from friends and family about their physical appearance:

> I am sure that I sounded vain, but I constantly needed to hear that I was beautiful. I am not even sure that it made a difference because when he would tell me that I would just tell him that he was 'just saying that' and he really didn't mean it. (Carol, 3.1).

> My sisters would always tell me I had this 'glow' about me and that I was a beautiful pregnant woman. I really needed to hear that because sometimes I felt really ugly inside. (Jessica, 10.1).

> I actually went so far as to almost demand that my husband...well, ex-husband, wrote down on little notes why he found me physically attractive. I didn't care when he said stuff like, 'you are sensitive' or 'you're kind'...what I wanted to hear was 'you have long thin legs' and stuff like that. (Hope, 8.1).

Some participants also received internal as well as external reassurances. For those participants who had a positive outcome in that they delivered a healthy baby despite their eating disorder, they utilized this previous experience as a reassurance about the healthiness of their current pregnancy. They felt they could take additional risks with this pregnancy:

> ...it was a little bit easier the first time...this time it is a little bit harder. I'm on the wrong road for a while but maybe it's because I know everything was OK last time...and so "oh, let's push it a little bit and see'. Maybe it's part of my mind that's doing that to me. (Abby, 1.1).

> ...the first two pregnancies didn't bother me too much. Once I found out I was pregnant I wasn't too obsessed with my weight or anything. I ate pretty good during the first two pregnancies but after my daughter was born, my second one, I started getting really obsessed with my weight and stuff again and...it was the most important thing in my life at the time....The first two were OK but not this one....With this one, I don't know why but I just haven't been able to handle the weight gain. (Donna, 4.1).

> Everyone told me that I was going to have a small baby with the first one and he was well over eight pounds so with the second one...well, I knew that things would be OK even if I was eating less and smoking more. I mean...so what if my baby would only be around seven pounds this time, that's still a healthy weight. Turns out he was over eight pounds as well. (Jessica, 10.1).

Participants did not always receive reassurance from the various sources they accessed:

> Oh yeah, everybody at that time knew because it was too obvious because I was so skinny and a lot of people did try to help but at that time I was just so far gone that I didn't want to hear it. (Donna, 4.1).

When this occurred, participants addressed the risks to the health of the baby versus the threat to their self-image and then engaged in protective behaviours to self and/or baby based on their assessment.

Participants also continued to seek reassurance from other sources. Seeking reassurance from self and others was a consistent strategy utilized throughout the protecting process.

## Assessing the Risks to Baby versus the Threat to Self-Image

The second action/interaction strategy of the social process of protecting is assessing the risk to the health of the baby versus the threat to self-image. The influence of factors such as fear, uncertainty, guilt, body image, motivation, support, and making the transition to parenthood, all played a crucial part in a participants movement on the protecting continuum--moving either towards protecting their own self-image as a thin person or protecting the health of the baby.

The assessment of risk to the health of the baby and the assessment of the threat to their self-image will be briefly explored prior to the introduction of the influencing factors. The influencing factors will incorporate a more thorough exploration of the dilemma faced by the participants when addressing the competing motivators of a healthy baby versus the pursuit of thinness.

### Assessing the Risk to the Baby

For all of the participants in this study, there was a general belief that their eating disorder was not healthy for the baby. However, the range of knowledge regarding the potential obstetrical complications was diverse.

Some participants were extremely knowledgeable about the risks to their baby whereas others were less informed. All of the participants who had disclosed their eating disorder to their health care provider belonged to the group of participants who were knowledgeable about the potential complications.

Several participants shared their knowledge of the potential risks to the baby:

> ...like if the baby was born malnourished or underweight of if you have...a preterm delivery because you weren't eating properly and just things like that. (Abby, 1.1).
>
> I know there is the risk of having a small baby...with not eating and smoking as much as I do. (Jessica, 10.1).
>
> The baby could come early...I knew that might happen and that if it did happen he would probably be small. (Francis, 6.1).
>
> I wondered about the long-term trauma to the baby. What if the baby was retarded or delayed somehow. Mentally something could be wrong if the baby's brain was starving too. (Ginny, 7.1).

Those participants who were receiving prenatal health care from a professional who was aware of their eating disorder were classified as "high risk". This lead to various emotions such as fear, uncertainty, and anxiety:

> Being labelled as 'high risk' just reminded me once again that I wasn't normal and that scared me because it wasn't just about me anymore. I didn't want my baby to be abnormal. (Bonnie, 2.1).

> I don't think the fear ever went away. I was constantly reminded that both me and my baby were at risk--high risk. I didn't even know what that meant particularly...I just knew that it scared me, really scared me....and I also knew that it was because of me that the pregnancy was 'high risk'...just try and live with that if something happens. (Francis, 6.1).

> I was really anxious when the words "high risk" were spoken. It got even worse when they started referring me to all sorts of different people. I wasn't sure what was happening anymore. (Abby, 1.1).

Three participants describe their health care providers as being more anxious and concerned about their pregnancies than they were:

> I don't know...I guess I looked healthy and my blood work was all fine...he never really pointed out anything specific...I took prenatal classes and stuff and they covered the nutrition thing there...he was more concerned this time around. (Donna, 4.1).

> I went to my family doctor for the test...then she sent me to see a specialist at the University because that's where the psychiatrist is. I got an appointment with him and he got a little bit more anxious than I did...quite a bit more. Then he...makes sure that I go to see the dietician...I see her everytime I go for an appointment. (Abby, 1.1).

> I was being monitored by a dietician, my doctor, my psychiatrist...I was being monitored by everybody. I guess they got scared because they threatened to hospitalize me if I didn't start to eat. (Bonnie, 2.1).

The researcher noticed that when exploring the potential risks to the baby, the participants often slipped into the second person when discussing this possibility. It was a way in which to further remove themselves from the reality of their situation. The "high-risk" label served as a not so subtle reminder that there were additional risks associated with having an eating disorder during pregnancy. This brought them closer to the reality of their situation.

**Assessing Threat to Self-Image**

Once the participants had evaluated the risks to the baby, they assessed their own risk and subsequently began to bargain with themselves while exploring the threat to their self-image. It appeared as though they were trying to balance the scales between two competing motivators: a healthy baby and the pursuit of thinness:

> Yeah, I always worry about 'what if I'm not eating enough?' or 'what if I'm eating too much?'. If I am eating too much then I won't be able to lose the weight later...that was kind of scary. It's more scary if 'what if I am not eating enough and then the baby...and the baby suffers from it and it's my fault...and I could have done something about it'....Well, on the other hand really, sometimes you can't...it's your eating disorder...you think you can do whatever you want but sometimes you can't always do that--even when you are trying. But I just don't want anything bad to happen and for it to be something I could have, you know, done something about...if I had been stronger or whatever...able to stop the eating disorder. (Abby, 1.1).

The participants in this study experienced intense emotions that were often in conflict. The eating disorder had long been established prior to pregnancy for all of the participants, so being faced with the dilemma of losing one's primary coping behaviour (ie: the eating disorder) in the presence of yet another stressor, that being pregnancy, was difficult to process at best. When assessing the threat to their self-image that this posed, that is the threat to their ability to pursue thinness, participants identified seven factors which were influential in their movement towards protecting their self-image and protecting the health of the baby.

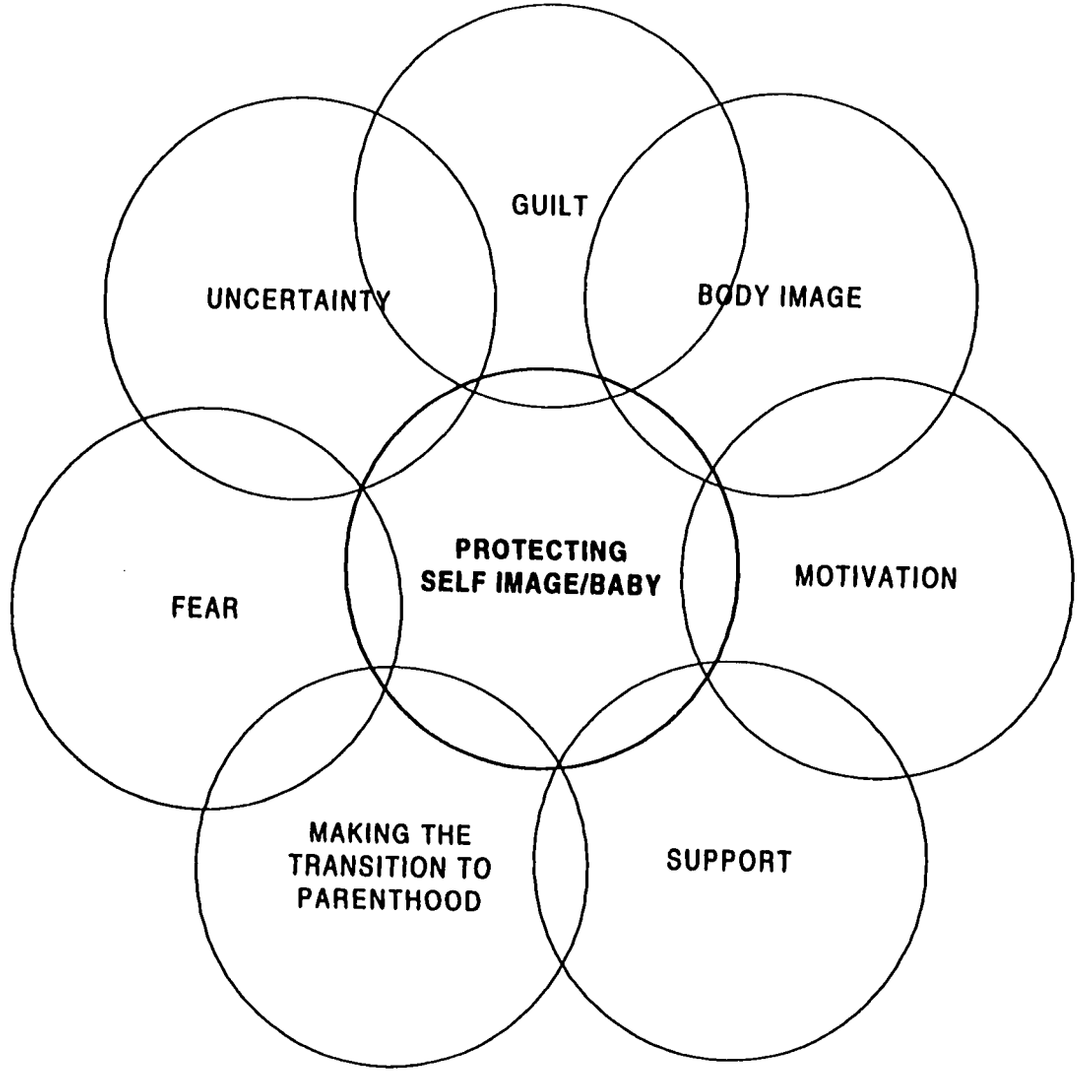


FIGURE 3: INFLUENCING FACTORS

## Influencing Factors

As the pregnancy progressed, the participants experienced various intense emotions which influenced the process of protecting self-image/ protecting the health of the baby. These factors include: (1) fear, (2) uncertainty, (3) guilt, (4) body image, (5) motivation (6) support, and (7) making the transition to parenthood. The first four factors are emotions which provided the reaction of motivation to alter behaviours. The successful action was dependent upon the degree of perceived social support. The final influencing factor was making the transition to parenthood. The interaction of these identified factors with the main theme of protecting self-image/protecting baby, can be viewed in a schematic model (see Figure 3).

### Stressors

The direction in which the women decided to move on the continuum, in either protecting their self-image or protecting the health of the baby, was influenced by a number of factors including previous history, the presence or absence of support systems, time of pregnancy, the influencing factors, and the current stressors or triggers they were experiencing. As the stressors experienced by the participants are closely interrelated with the protective behaviours, they are reflected in the stories told by the participants. They will be included in the exploration of the influencing factors. The significant event leading to the stressors experienced varied but they had one key quality in common--they were interpreted and internalized as either a threat to the pursuit of thinness (negative stressor) or as a risk to the health of the baby (positive stressor). The risk to the health of the baby was seen as a positive stressor due to the positive influence this perceived risk had on the protective behaviours exibited by participants.

The negatively interpreted and internalized stressors were a threat to the thin self or to the self as seen through the body and included such events as: hearing or seeing numbers increasing on the scale during prenatal visits; comments made to the participants on size, weight, or appearance; stressed relationships with significant others, including relationships with health care providers; the participants' clothes not fitting anymore; and people, sometimes total strangers, feeling as though they could freely touch a participant's body simply because she was pregnant.

The positively interpreted and internalized stressors were those events which suggested a risk to baby and therefore served as a motivator to engage in protective behaviours for the goal of having a healthy

baby. The women had to balance the risk or negative threat to the baby against the negative threat to their own self-image or pursuit of thinness. These events included such things as: a suggestion from the doctor or health care provider that the baby may be at risk; lack of weight gain thereby threatening the health of the baby; comments made about inappropriate behaviours such as food restriction; uncertain outcome; and supportive relationships with significant others.

The interplay of the stressors with the influencing factors will be explored in the next section.

## Fear

*The fear of freedom is strong within us.*
*Germaine Greer*

Fear is a raw emotion--one which was present for all of the participants of this study at some point and in some form during their pregnancy and beyond. The main sub-themes of fear identified by the participants include: the fear of gaining weight/fear of fat; fear of labelling; fear of exposing the underlying issues; fear of gender of the unborn child; fear of surviving labour; and fear of autonomy.

### Fear of gaining weight/Fear of fat

The fear of gaining weight and the fear of fat were, by far, the most prevalent identified fears by the participants. Their stories were endless about their fears of gaining weight and being fat. Their fears of gaining did not, however, prevent many of the participants from engaging in healthy behaviours which allowed many of them to gain an appropriate amount of weight during their pregnancy. This was not an easy dilemma or challenge but the participants met this internal struggle with all the strength they had as is evident in their stories:

> I think what I found the hardest was going to the doctors office and they always weigh you. I had to get to the point where I had to tell them not to tell me because I was just...I couldn't hear the numbers going up on the scale...and in some ways going to the doctor was great because they would really encourage you and say 'you look good' and 'you are doing very well' and so you have that boost for yourself but everytime he told me how much I weighed it was just terrifying and I thought, 'Oh God!'. (Bonnie, 2.1).

> Fat--I don't want to gain weight, even though I know if I didn't eat for two weeks straight I'd probably still gain a pound because the baby's getting bigger but I wouldn't think 'Gee, that's just the baby gaining and growing on its own', it's me and that's hard to take and that's why it's so hard to handle even one pound a month. It has been tough. (Donna, 4.1).

> I'm not weighing myself anymore...and I didn't weigh myself until...I waited a long time because I knew that if I saw it on a scale I would totally flip out and not eat at all. At least this way I was eating a little bit...not...well it wasn't a lot but it was better than if I would have seen the scale. (Abby, 1.1).

> ...going into labour early...that would scare me and I would think 'Oh God, it's because I'm not eating right', and so then...I would just smarten up again, but if I went to the doctor and he gave me shit about gaining more weight then I'd go back and...it was a pattern--the week after I had gone to the doctor I was doing it [binge/purge]more often. Or I would do it just before I would go in to see him...I would restrict just before I would go in. A couple of days before I remember taking the...the diuretics and the laxatives so that I could drop a couple pounds before I would go in to see him so that when he weighed me he wouldn't...you know, didn't give me that hard time like that. (Eva, 5.1).

Several of the participants experienced a fear of gaining weight, and one of the more stressful events in the participants' lives was having to be weighed by their health care provider, as was evident in the above participants' stories. One participant in the study who had disclosed her eating disorder to her doctor chose not to know what her weight was each prenatal visit since she knew this was a trigger for her:

> I couldn't get him to agree to not weigh me at all, so I guess you could say we compromised. I allowed him to weigh me each week as long as he didn't tell me what the numbers were. I just knew I couldn't handle hearing him say, 'Oh, you've gained this much or that much', so this compromise worked out OK. I knew that I was getting bigger and gaining weight but for me, for some reason, not attaching a number to that was helpful--maybe even a lifesaver. (Francis, 6.1).

One participant said that she felt it would have been helpful if her health care provider had made the same compromise:

> It would probably be better if I didn't have to see it--in fact I think the next time I do go I'm gonna not look, tell them not to tell me because it will upset me and it will be another big scene in the office and...I don't need that....this is right towards the end so most likely I've gained another pound a week whether I've ate or not and so, it's going to be there, I know it and so if I don't know about it then maybe it won't bug me as much. It'll still be in the back of my mind but I won't have any proof of it and I don't have a scale in the house so I won't be able to verify it. (Donna, 4.1).

**Fear of labelling**

Many of the participants in this study had suffered from some sort of label in their lives, often a label which was given to them early in life and never enhanced their self-esteem. When participants disclosed their eating disorders to family, friends, and health care providers, they were met with similar apprehensions, judgements, and labels which adversely affected their interactions with these individuals, and the memory of these experiences ran deep. As a result of previous experience with labelling, the majority of participants did not disclose their eating disorders to their health care providers; For those who did, the results were varied.

Two participants share their experiencing with being labelled:

> I thought that I was going to have a hard time. I thought that maybe they would look at me and think something badly of me...because I felt bad in myself....Like I was so afraid of having a mental illness...of going...well, it's still like that...of going to any doctors, you...right away you're labelled. You're a thirty year old, emotional female, and you have this psychiatric label and it's scary because you...you're afraid to share that sometimes because of that experience with other types of doctors....It isn't just from male doctors and it isn't just females. It's...it can be nurses, it can be...you know, it can happen wherever. Emergency is a really good place for it to happen because once they learn your history...it can happen. (Bonnie, 2.1).

> ...you know you're supposed to quit smoking, you're supposed to quit drinking, and most people do that, and you know, some people do that before they even get pregnant because they are anticipating it...and it's like, with an eating disorder people look at you and it's like, 'well, you can stop that too, it's something you can control' and they don't realize you can't control it. You couldn't control it before, you can't control it now. Just because you are pregnant it isn't any different--you can't make it go away. (Donna, 4.1).

**Fear of Exposing the Underlying Issues**

The fear of exposing and having to deal with the underlying issues which were surfacing in the absence of an active eating disorder was very real for some of the study participants. Two participants shared their stories of having to deal with their fear:

> Whenever I have this really uncomfortable feeling inside, I turn to food. I don't actually ever know that something is wrong inside, I just get this insatiable urge to stuff my face, and keep doing it until I hurt inside. When I look at it now, I am replacing one hurt--the subconscious kind--with a physical hurt, so I am never aware of the one that's deep inside.

> I know that it sounds simple but it has taken me years to reach this place...this level of understanding about myself. Going deeper within is scary, and I don't feel safe. (Ina, 9.1).

> It made a difference for me when I was able to connect the two. I was physically starving myself for a reason...because I was emotionally starved. It's that simple...and it's painful...more painful than I could ever describe for you. A wounded child...that's who I still am. (Jessica, 10.1).

Pregnancy was an event in these participants' lives which exposed the painful underlying issues. Since there were competing motivators at this time, participants could not always fill their void with food, but rather had to face the issues as they surfaced:

> I was constantly eating to fill...maybe fill something...maybe a void at that time. (Eva, 5.1).

**Fear of Gender of the Unborn Child**

Although discussion surrounding gender of the unborn child was not a planned part of the interview, some participants reported having issues with the gender of their children:

> I was a little more scared the second time around. Not because of having...being pregnant. Some of the fear came from...if this is a girl....You know, I didn't feel that with the first one because I had a feeling that it was a boy and that was it. The second one...I guess the pregnancy itself felt so different that I didn't know what was going on. (Eva, 5.1).

> I know when I had my little girl I was frightened. In some ways I thought this was justice in that I could do this right and not have what happened to me happen to my daughter...but that scared me too because what if I failed...what if she had to experience what I did...I wouldn't be able to cope with it. I had such mixed emotions...seeing her reminds me of myself and that's pretty painful at times. (Bonnie, 2.1).

The participant with a history of physical abuse expressed relief at having had male children:

> I have two boys and I couldn't be more pleased. No one is going to mess with my babies...I am reassured knowing that they won't have to put up with that garbage. (Jessica, 10.1).

**Fear of Surviving Labour**

Many women fear labour in itself, and their ability to cope with the pain. For women with eating disorders during their pregnancy, the fear of coping with labour is intensified in that there is a significant fear of even surviving, let alone coping, with labour. Eating disorders have numerous physiological effects on the body, many of which are life threatening. These physiological effects in combination with the stress of pregnancy and labour can place a woman at increased risk during her pregnancy and labour. The risks can be minor or major ranging from fainting during labour to heart palpitations, to full fledged cardiac or respiratory arrest.

Several participants expressed fears of surviving labour as a result of their eating disorders. Here are three of their stories:

> I think about that sometimes...that I'll be in the middle of labour or something and I'll have a heart attack. My heart won't be able to take it. My blood's really bad right now. Like I'm really anaemic. Like I add something new in the diet and I really worry about that but...it'll be wrong. My doctor keeps telling me that my blood is so bad that he might stick me in the hospital on an iron infusion which I don't want to do...and he said afterwards it could be real bad. He's worried about that...like, you know, haemorrhaging really bad or having a heart attack and dying or....There's risk to myself but strangely enough it's not myself that I'm worried about. It's N. and what will happen to the baby and who is going to take care of it. Like I could probably deal with dying on the table but then like who's going to look after the baby and my other two kids. (Donna, 4.1).

> I fainted throughout much of my labour, so to be honest a lot of it is a real blurr. I had expected labour to be intense, but I was also suffering from having not eaten in a few days and also from being really dehydrated. I felt dizzy a lot of the times...like regularly during the day but I was having an even harder time in labour. My heart was racing, my head was racing...I just couldn't keep it together. (Bonnie, 2.2).

> People laugh and joke about making it through labour but...I was serious about not thinking that I would make it through...I wasn't just talking about getting through it without taking pain meds, I meant actually surviving! (Ginny, 7.1).

All the participants in this study survived the labour experience, despite their fears. One participant fainted frequently throughout her labour, and four other participants reported feeling excessively dizzy and having "racing hearts". The researcher did not confirm this data using medical records.

**Fear of Autonomy**

Autonomy is a significant theme for women suffering from eating disorders during their pregnancy. Autonomy is conceptualized in the literature as self-assertion, making one's own choices and deciding on one's expectations for oneself. This has historically been a difficult characteristic for women with eating disorders to develop, as well as for the participants in this study (White, 1992). Once the event of pregnancy occurs for women with eating disorders, they are faced with having to become increasingly more autonomous as the unborn child--soon to be baby--becomes increasingly more dependent upon them.

Some of the participants shared their fears of autonomy, and conversely dependence:

> I am so scared of being in charge of caring for this baby...having to make decisions that will affect another human being directly. When it's just me, I know how to play the game, I can present this "false self" as a defence against my fears and insecurities...I can be the perfect child, perfect daughter, perfect wife...but I don't ever see myself as being the perfect mother, and that will be what is expected of me. I can't do it on my own...I can't have a baby be dependent on me for survival when I struggle with my own sometimes. That's really scary for me. (Ina, 9.1).

> I remember when I was a kid, I used to love the idea of having a baby, someone that would love me unconditionally...someone that I could take care of and be this like...perfect mother. Well, growing up sure put a hinge into that! I struggle with my own relationship with my mother and what has become obvious is people, even mothers, do not love unconditionally or they wouldn't go putting all those pressures on their children. I don't want to blame my parents but they sure do have influence over their children...I'm frightened of that because I don't think I can do this, even though I always dreamed of being out on my own looking after my baby...now I am not so sure I am capable. This baby needs me and I am scared of that...that and also that I won't measure up. (Ginny, 7.1).

> ...now I am responsible for this child, me alone...what that means is if I screw up, I will have only myself to blame. I don't know how to be responsible for all the things I will need to be for this baby. The demands of being a parent and a good mother are beyond what I can imagine and cope with. I mean...before I could cope using my eating and stuff but I don't want this child to grow up thinking I...this is how you do things. This baby will come closer to me than anything in this world, and because of that I am vulnerable, and I am not sure how to cope with that. I feel like I need to become more independent and assertive in my life...but that's a whole big bunch to ask of myself on top of dealing with everything else in my life, including the baby. After all, I have had years of practice not taking control of my life, except for my eating, and now it will be pretty hard to change years of unhealthy stuff. (Francis, 6.1).

The participants shared feelings of failure to develop autonomy early in life predominately due to over-control and intrusiveness by their parents, namely their mothers. As a result of this lack of autonomy early in life, the participants have felt vulnerable and unable to cope with the multiple demands and implications of being pregnant and having a child. There is fear of autonomy yet participants felt strongly that in order to be good mothers, they would need to develop greater independence and assertiveness in order to fulfill that role.

## Uncertainty

The theme of uncertainty had many different meanings for the participants. Initially there was uncertainty in the ability to conceive a child. Once conception took place however, the uncertainty turned to: being able to maintain the pregnancy; being able to cope with labour; uncertain outcome as to the health of the newborn; and uncertainty in parenting ability. The sub-theme of "being able to cope" was indirectly addressed in "Fear of Surviving Labour" in the previous section.

### Maintaining the Pregnancy

The women were aware that there were some risks to their pregnancies and to their unborn children as a result of having an eating disorder during their pregnancy. The degree of knowledge that each participant had varied, but despite the level of knowledge attained, all participants experienced some degree of uncertainty about their ability to maintain the pregnancy:

> I knew that if I tried my best...which for an anorexic is hard because it still isn't good enough. I knew that if I tried my best, then if something did happen to her I could at least look at myself and say, 'I tried' and not...have given it a chance. (Bonnie, 2.1).

> I wasn't confident that I...that something would happen early on that would prevent me from having the baby. I thought about my getting sick and all and that maybe I would have a miscarriage because of my throwing up. I also thought that...well since I hadn't had a period in so long that maybe my body wouldn't keep the baby inside...I don't know if the makes any sense, but that's how I felt. (Ginny, 7.1).

### Uncertain Outcome

The outcome of pregnancy is birth of the baby. This event was greeted with both apprehension and anticipation by the participants. The women in this study have had long history's with expectations that were not met, thus leaving the participants somewhat unwilling to commit themselves to fairy-tale storybook

endings. Participants feared that their eating disorders might have adversely affected either their baby's mental or physical status:

> ...every time it moves I'm relieved because I think it's still OK and every time the doctor tells me that the heartbeat is good I'm relieved because I know that it's OK...but it's hard. I'm so worried. I'm really scared this time around that there's something going to be wrong because I didn't eat enough this time and I didn't take vitamins....I'm scared there'll be something wrong, horribly disfiguringly wrong with it or mentally wrong with it like I starved its little brain or something...that it'll be retarded or whatever...I'm terrified of that...I guess it's not so much physical disfiguration but mental. Like the brain didn't develop because it wasn't fed or something...really worries me that the baby won't be right. (Donna, 4.1).

> I think I have a certain degree of fear walking into a pregnancy anyways because I know all the things that can go wrong even with a totally healthy woman...but I was extra anxious about delivering the baby because I didn't know what to expect. I kept thinking, 'OK, did I eat anything that had iron in it? what about folic acid?'...what if I starved the baby and I had this little "Ethiopian-like" baby that maybe doesn't survive. It just made me feel sick inside....I wanted someone to assure me that the baby was OK for sure...I guess there never is that kind of guarantee. (Hope, 8.1).

The researcher noted that when the participants were discussing uncertainty, they referred to the baby as "it" or "the baby", rather than "my baby". This is common when talking with expectant mothers.

## Guilt

Guilt is an emotion which has a long history with women suffering from eating disorders. The participants in this study were no exception. For the majority of these women's lives, they have been made to feel guilty and responsible for events and actions for which they had no control, such as abuse or failure to live up to the expectations of others. Guilt is a deep rooted emotion that takes on even greater power when a woman feels she is responsible for harming her unborn child. Several participants shared their feelings of guilt:

> ...I didn't want to feel guilty about one more thing in my life. I didn't want that to be another thing that I would go to my grave with...and I thought if I could give this baby a chance...that maybe things would...I don't know...be better somehow. (Bonnie, 2.1).

> During the pregnancy itself...there were times when I would be feeling a little guilty. I was always afraid whether it was going to harm the baby, at the time I didn't know that I was having twins. I was concerned whether they were going to be OK. (Eva, 5.1).

One participant had even been having dreams about her guilt:

> I've been having a lot of really bad dreams that there's something wrong with the baby and it will be my fault and I'll know it will be my fault and I will have to live with that for the rest of my life. All from the sake of having a stupid hang-up about my weight...hopefully it won't turn out that way. (Donna, 4.1).

Donna reported being embarrassed by her fears and feeling as though if she were to vocalize them and have ownership of her fears, then if they came true it would be like self-fulfilling prophecy:

> Strangely, no, I haven't been able to discuss these fears with my doctor because I'm embarrassed because, I guess, if I didn't say anything to him and something did go wrong then I could convince myself that it wasn't my fault and yet I would know it is but if I, like, speak my fears to him right now and say, 'well, I'm not eating very good, I'm scared something's going to happen to the baby' and then something did happen to the baby then he would know I was guilty too. Kind of terrible but it's true. (Donna, 4.1).

For many participants, guilt also surrounded the fact that they ate, what they ate, and for some that fact that they didn't eat:

> I mean I had the odd ice cream cone but not without having guilt. (Bonnie, 2.1).

> It's terrifying me this time 'cause I'm scared for the baby. I tried to convince myself that, 'well, the baby can just live off the existing fat that are already there' but I know that's kind of a myth and it...some days I just sit down and I cry because I am thinking, 'Oh, what am I doing, what am I doing?', but on the other hand I just can't make myself eat and I justify it. Like, 'Oh, but I ate this little bit and that's enough for the baby'....It's just like I can't overpower that feeling all the time and sometimes I can and I go 'you've got to do this for the baby' and other times I'll be in tears as I'm not eating because I know it's wrong. I just can't make myself eat. (Donna, 4.1).

> I feel guilty all the time...when I eat, when I don't eat, if I eat too much, too little, all the wrong things, all the right things...then I feel guilty about not feeding the baby... (Carol, 3.1).

Guilt appears to be associated with the mothers' knowledge that they must eat in order to produce a healthy baby while at the same time they feel unable to justify eating. This is part of the dichotomy they encounter in balancing the need to protect the baby while still protecting their own need to remain thin.

## Body Image

Women with eating disorders have identified distorted body image as central to their preoccupation with weight and their pursuit of thinness. During pregnancy, issues of body image assume an increased role since the body is adopting a shape that is both uncontrollable and frequently undesirable to the woman. The women in this study experienced conflict with their changing body shapes and sizes, and the trimester of the pregnancy influenced the extent of discomfort and of the conflict.

For example, Eva and Ina spoke about their feelings in the first trimester:

> ...you know 'cause when you are first pregnant you feel just fat. (Eva, 5.1).

> I hated my body to begin with, and then once I got pregnant...even at the very beginning, I felt fat and ugly. Maybe it was a sign of things to come but I just know I didn't like the way my body looked very much. (Ina, 9.1).

For some women the second trimester created the most intense feelings about body image:

> I think that it would be the same time that any woman feels like they are having a more difficult time in dealing with their bodies and what they are seeing in the mirror. That in-between time when...the clothes aren't fitting anymore and you want to fit your jeans still and yet you don't really look...pregnant. (Bonnie, 2.1).

> I hit this in-between stage that was the worse. That's when I could tell that people weren't sure whether I was just fat or whether I was pregnant. I kind of made an effort to mention something about my pregnancy because I didn't want them thinking I was fat. I hated that stage...about five, six, even seven months pregnant...it felt awkward, and I felt fat and totally shapeless. (Ginny, 7.1)

> I was probably the worst during the second part, you know...around five or six months. I just couldn't identify with this shapeless fat body. Nothing fit clothes-wise...not my regular stuff and I couldn't bear the thought of wearing maternity clothes. I would have really hit "fat-dom" then. I really struggled with my eating then. (Hope, 8.1).

For others, the third trimester when they looked big and when the growing uterus interfered further with their eating was the worst:

> I think one of my biggest challenges was the last part...you know when nothing feels right...you just feel like a beluga whale. That part is tough because it is really easy not to eat...there is so much pressure on your stomach anyways so not eating is really easy...and my body was...well, really tough to look at and yet everybody wants to see how pregnant you are, and they feel like they can just touch your stomach just because it is sticking out a mile. That made me really uncomfortable. I felt like...was like this pregnant fat lady waddling around. (Carol, 3.1).

> What other time would have been hard? The very end I would say because you're...you just look so big and...I think I felt really...I thought it was really neat because I could feel the baby and that too but...I think it was also pretty frightening...towards the end because I knew she was coming...and once she was out..what was my body going to look like... (Bonnie, 2.1).

The majority of the participants felt that the second trimester was the most difficult since it was "in-between" being thin and being really pregnant. There was some concern about public perception during this time in that some people may just think that the participants were fat as opposed to pregnant. The second most difficult stage was third trimester due to the obvious body size, shape, and weight changes. The first trimester was reported to also be a difficult stage but it was also reported by the participants to be perhaps more of a psychological response to what was to come later in the pregnancy.

Participants also explored some of their thoughts and fears about what their bodies would be like once they had the baby:

> ...and you still have this 140 pounds in your brain and they kept saying, 'No, Bonnie, twenty pounds is probably going to come off right away and you don't have to worry'....I was worrying! (Bonnie, 2.1).

> ...I went through feeling like I didn't like being a woman, didn't like the breasts but it...I felt like OK, getting skinnier or slimmer or whatever is doing the opposite of what I want so then I'll gain the weight, but then with that...what I didn't expect was that my breasts got bigger, my hips got bigger, and I'm still a lot bigger. It's a catch 22. (Eva, 5.1).

Some participants commented on how they would handle their body image following delivery:

> I know I'm already planning to starve and exercise even more once the baby's born and maybe even taking up smoking again...cause it's driving me crazy right now. I just want to lose the weight while I'm pregnant and it's physically impossible for me at this point. I don't know how to do it any other way. I've tried living off lettuce and stuff like that and it just doesn't work for me. I think that secretly lettuce has been fattening all the time and nobody told me because I can live off the stuff and I don't lose weight. (Donna, 4.1).

> I know how the part of my mind works...that is the eating disorder corner part of it. If the baby's born, then I'm not eating...and that's it. I don't know if I'm gonna...I don't know how I can stop that because last time I couldn't stop it...and I know how...I know how to do all the tricks and stuff...and fool people and that kind of thing and 'Oh yeah, I'm eating' and I know all that stuff and I know I can do it but I know that it's not good. It's not the healthy way, but I...I just know that part of me...in my mind right now it's gonna do that. (Abby, 1.1).

Body image was often related to clothes and how the clothes were fitting. The changes in body size that accompany being pregnant caused clothing to fit tighter, or not at all, which often served as an influencing factor for participants.

> And knowing that I had to eat and had to eat quite a bit...was very scary...feeling my clothes getting tighter was also very scary...I spent quite a bit of time crying. (Bonnie, 2.1).

> At first it was not fitting into clothes. My jeans. As soon as I had to stop wearing my jeans even though I knew there was a perfectly good reason for it--that at four or five months pregnant, you don't fit into their regular size 27 jeans....Even though common sense tells you that you shouldn't be able to...it still drove me crazy...it really bothered me...and now I can't even get into sweat pants...my body...it's awful, I hate it! (Donna, 4.1).

## Motivation

Motivation was a key theme for participants in this study. Women were intensely motivated to have a healthy baby and also to remain thin. At times these two goals were in conflict with one another. Motivation was a reaction to the emotional factors of fear, uncertainty, guilt, and concerns about body image.

## Having a Healthy Baby

The motivation to have a healthy baby was dominant for several of the participants. The intense maternal emotions of wanting to have a healthy baby influenced women's decisions regarding the activeness or negative influence of their eating disorder on this desired outcome. Throughout the interviews, women spoke of their desire to have a healthy baby. This concern was evident in the pre-pregnancy period when a child was contemplated, during the pregnancy, and post-pregnancy.

### Pre-Pregnancy

For a few of the participants in the study, the pregnancy was planned and their behaviours relating to their eating disorder were altered in order to increase their chances of becoming pregnant:

> ...if you're trying to have a baby then we kind of try to do better because then you know you have to excel in that time. (Abby, 1.1).

> I knew that I would have to make a few changes before I could conceive...it was just figuring out what I could and could not get away with. I wanted a baby though so I knew I needed to eat. (Carol, 3.1).

> I wanted to be pregnant....and I was very determined when I was pregnant that I was going to be very strong, that I didn't need anybody's help, that I could do this on my own. You know, a lot of those fears that women have when they're pregnant, labour and stuff...I never had those fears. I figured I could handle it. (Eva, 5.1).

> Although my eating disorder was pretty severe, I knew I wanted to have a child and in order for that to happen, I had to stop starving my body. I had to stop exercising like crazy because if I didn't...I would never have a baby. (Francis, 6.1).

### During Pregnancy

The motivation to have a healthy baby was intense for the vast majority of the participants. The women experienced and overcame many struggles during this time in order to maintain their commitment to their unborn child. Bonnie and Abby spoke of their experience:

> The first three months were pretty hard. I spent quite a bit of time in bed. Quite a bit of time crying....I had it in my mind that I had to get well for the baby. Otherwise I was going to lose the baby. I was kind of given the impression, not in so many words, by the doctors that if I didn't somehow try to eat and get some vitamins going on and stuff like that...that I probably wouldn't be able to carry him to term...and that I would lose him. I just had it in my mind that I can't do this for me...I'm going to do it for my...the baby. (Bonnie, 2.1).

> So I thought, 'well, I can't do this'...exercise this much...so then right from that day I cut it down and I cut it down more...and it was easier to do because I...because I knew that it was bad for the baby to do...overdo it...the last few months I've kinda stuck to what would be normal. (Abby, 1.1).

There was evidence that the women balanced the scales, weighing the need for the baby to grow against their need to remain thin. Abby explains:

> I know I want to gain weight...for the baby but I don't want to gain any for me, but you can't really do that....I would be scared if I really restricted myself that the baby would be malnourished or underweight or....I don't like to sit back gaining weight but it's not so bad because I know it's the baby and all the things that baby needs and...and that makes it not as scary. (1.1).

For some participants, pregnancy also provided them with "permission to be fat" and therefore to be confident in their minds that the baby was getting adequate nutrition and would have a good chance of being healthy. Some participants reported being "free" for the first time in their lives:

> I just thought, 'I gotta eat, it's OK--I can gain weight now'...it was so great! I could eat. I can get big and that is just what happens when you get pregnant and so nobody is going to say, 'Oh, you've gained a pound or two!'--Nobody is going to point it out because you are obviously pregnant so you get big....It was a freedom. (Donna, 4.1).

> Like once I could actually see that...you know 'cause when you are first pregnant you feel just fat...but when you're...by the time you're about four months and five months and you're actually...you can feel the mass of the uterus, you can actually feel that, I used to think that it was so neat...and I loved the feel of the babies moving and stuff and I thought that was...you know it was a real change for me. (Eva, 5.1).

> Being pregnant is a liberty to get fat. It is freedom for me...freedom from having to be thin, and hungry all of the time, and starving...It is like a reason to get well again. I love it. (Francis, 6.1).

> For the first time since...well, probably since I was a little girl, I could eat and not be facing this internal struggle of whether I should make myself sick again or not. I knew the baby needed it. (Ginny, 7.1).

For the participants who felt liberated from their eating disorders because of their pregnancies, eating and gaining weight were welcomed actions and responses because it was desirable for the baby.

**Post-Pregnancy**

Most of the participants in this study reported having an extremely difficult time remaining motivated following the birth of their babies. For the majority of women, their eating disorders returned to the state they were in prior to the pregnancy, and for many, their eating disorders intensified postpartum.

In keeping with the theme of having a healthy baby, having children motivated one participant to deal with some of the other issues and stressors in her life:

> I think...having my children definitely made me want to disclose the fact that I was abused because there was no way that anyone was going to do that to my children and I was very protective of my children....Even though they are boys, I am very protective of them. I did not want to have girls...I think it would have been a lot worse if I had a girl....My reaction to what happened to me...I am...being as protective as I tend to be. (Eva, 5.1).

Having children has also motivated Eva to be protective of her children, an experience unfamiliar to her in her own family of origin. Many participants had issues of abandonment in their histories and keeping that in mind, new mothers did not want to be unavailable for their own children:

> ...that protective thing...they're at an age now...that they are just learning and experimenting themselves and I want to be there for them to...work out whatever problems that they have that...again looking at my mother who wasn't there. (Eva, 5.1).

During the interview, Eva was able to connect for herself the relationship between underlying issues and her eating disorder. She was also able to identify that she wants to get well and return to what she calls a "normal life":

> I think what triggered it was we...we decided that we were definitely going to build, we were going to work out our problems, we were going to deal with the issues. I think that's what it is--is dealing with the issues. The combination--and its just clicked with me now--are connected. Like my mother...didn't see that I was being molested, my husband just didn't see that we were having a marital problem--he denied it--and when he realized that, yes, we were having a marital problem, that clicked it, that made me then switch over...and like now, I'm doing OK. I want to get back on track, I want to get what I call a "normal" life, and "normal" eating habits cause I've stopped cooking, I've stopped doing all kinds of things. (Eva, 5.1).

Children can be an incredibly strong motivator to get individuals on the right track and moving towards healthy behaviours.

**Pursuing Thinness**

The need to be thin was dominant for some of the participants. It was a desired state but after weighing the risks to the baby, the majority of participants engaged in healthy eating behaviours. Some, however, felt they were unable to cope with a growing body, despite cognitively being aware that it was due to the growing baby. For them, the pursuit of thinness was strong and ingrained in them from years of using their eating disorder as a coping mechanism. While their motivation to be thin remained during the pregnancy, it was more intense postpartum.

The pursuit of thinness was present for all participants prenatally, it was only upon discovering that they were pregnant that they began to face competing motivators. This pursuit was not always consistent, it varied depending upon the various stressors that were being experienced; the personal history and available support systems. However, it was evident that some participants continued to actively pursue their goal of being thin during their pregnancy. For them, the fear of being fat outweighed their concerns for the baby:

> If someone were to say 'Oh, it looks like you've gained weight', Oh, that would blow my mind. I'd just...I'd go out and find diuretics. That would just send me over the deep end and after somebody did make that near fatal mistake on their part, actually in July somebody said something to me about my eating and I just...I don't know why, it was already bad before that but it just really ticked me off...(Donna, 4.1).

> It was really hard 'cause you see, I believed that I was fat to begin with, and thinking that I would be getting bigger, well that was unacceptable. The way I thought about it was that if I could lose weight during my pregnancy, then when the baby was born, well...then I might be down to my desired weight. (Jessica, 10.1).

There was a strong and determined pursuit of thinness by several of the participants following the delivery of their baby. The postpartum period was riddled with conflicting emotions but for the majority of the participants, they believed that because the baby was no longer relying upon them for its nutrition, they could return to the behaviours which promised them quick and effective weight loss:

> Oh, how I hated being fat again...I didn't eat. The first week I was home from the hospital I lost 27 pounds...I didn't touch a morsel in the first week I was home. Nothing...and I exercised like crazy. (Donna, 4.1).

> I think it goes without saying that I would try to lose the weight right away and as quickly as possible. Well, the best way for me to do that is to stop eating, or at best restrict to simple foods like fruits and vedgies and stuff. I don't really want to begin throwing up again but if I feel like I am not succeeding at losing weight, then that's what I would have to do. (Carol, 3.1).

> I will begin running again. That's one thing that I can do that will help me drop the weight pretty quickly...that and not eating. I don't want to use any other vices but I will do what I have to do in order to lose the weight. The plan is not to really gain much, if any, but if I do...well, off it goes...the sooner the better. (Hope, 8.1).

Motivation toward certain behaviours existed for all participants although the direction in which the participants were motivated was in conflict much of the time. At times the motivation was for a healthy baby and at other times participants were motivated towards being thin.

## Support

Women with eating disorders often find it difficult to allow others to help them deal with their issues, yet they describe having support as crucial to their healing. For the participants in this study, it was the influence of support from family, friends, health care providers, and support groups that made the difference between continuing to pursue thinness or moving towards behaviours to assist in having a healthy baby. Fortunately, most participants had some supports, although it was often limited, and they were able to move in the direction of having a healthy baby.

### Family and Friends

Support from husbands, family and friends was reported as being influential in making it through the pregnancy. They did this by being non-judgemental, by understanding the problem, and through just listening to the women's concerns:

> I was fortunate to have a very loving spouse and that made a very big difference because he is not the type of person to babysit me as far as 'Bonnie eat', 'Bonnie do this', 'Bonnie do that', because that's just dependency and control again...but he was encouraging...there was a difference. A big difference. (Bonnie, 2.1).

> ...and I felt safe with the few friends that I had that I could eat with them and stuff like that. My husband...it is empowering to know that someone else understands...and to know that it is what it is that's bothering me and that it is not the food. (Eva, 5.1).

> My husband was wonderful and it was with his support, and my sisters' that I was able to make it through sometimes. They were really fabulous and I am not sure if they ever realized just how much impact they actually had on me. (Jessica, 10.1).

> I had a really special girlfriend that I could share everything with...so she was a life-saver when it came to my pregnancy. I don't know how many times I called her crying my eyes out...she never judged me or said I was bad, she just came over and listened. She listened! Wow...how she knew that's what I needed, I'll never know...but God bless her because I truly believe she's an angel. (Carol, 3.1).

**Health Care Providers**

Positive support from health care providers was reported to be extremely beneficial to the outcome of the pregnancy:

> ...going to the doctor was great because they would really encourage you and say 'you look good' and 'you are doing very well' and so you have that boost for yourself... (Bonnie, 2.1).

While the support received by participants from healthcare providers was seen to be predominately positive, for those women who had previous abuse histories, or who had difficulty relating to males, having to interact with men could be problematic:

> It was difficult to see a male obstetrician. I had all these sexual abuse issues that were still kind of fresh to deal with and some of them are still surfacing....I was pretty raw. I was kind of scared. (Bonnie, 2.1).

> I would say the support of having the hospital support was really good....Talking to them was helpful. I found talking to N. and L. was easier because they were females....females have probably dealt more with eating issues because more females face that struggle every day. (Bonnie, 2.1).

Bonnie was referred to a male obstetrician despite her fears. Once they developed a trusting relationship, Bonnie reported feeling better about her health care provider:

> ...we had a talk before my first appointment and he was so very good and my honesty...he commended me on that...he...I don't know...he was very good so he really...he helped a lot. I don't think if I'd had that time to talk and...get that support that I maybe I wouldn't have felt so good....I mean I was pretty stressed for the first little while...but as it turned out, they treated me very well. (Bonnie, 2.1).

**Support Groups**

Self help groups were also seen as a source of support for participants:

> ...being in a self-help group keeps it in check very much so because you see the struggle in other people and you remind yourself of the struggles and how difficult it can really be. (Bonnie, 2.1).

The need for additional support systems was expressed by all of the participants, preferably composed of individuals who had a similar experience:

> ...I've had a few friends where I've been able to talk about it and stuff but it's always...I find, it's better to be in groups that have...experience in this situation. Like you can talk to someone who's never experienced this stuff and they don't get it and then when you are in a group that can sit down and talk about things and they can say, 'Yeah, I remember this scene and this and this happened to me and that's how I felt' and...because a lot of times you get empowered by what they say because then...it hits whatever that you've been feeling and even though you are not aware that that's what you are feeling, you realize it. (Eva, 5.1).

> ...there wasn't anybody that I knew of with an eating disorder and actually sitting there pregnant at the same time I was...and had the baby and kept it and everything was fine....It would definitely been helpful for me to know somebody. I think that it's helpful for people with any kind of problem that they have someone in their life that has the same problem...that they can kind of share with as long as that person is in the same type of...they're in the same frame of mind...they want to try and get better and...they want to try and nurture themselves and look after themselves. Like I wouldn't want to be in that situation with a sixteen year old anorexic that really didn't want to live...really was starving and hated the world. That wouldn't help my situation at all. But another woman kind of with the same issues...that type of thing would have helped a lot. (Bonnie, 2.1).

> ...there's nothing out there. You look in the paper and there's something for everything but eating disorders. It's like a big secret, it's embarrassing and nobody wants to deal with that so...we'll sweep it under the carpet...if there was a support group I'd be there...because it's easier talking to somebody who's been there, who can relate...one way or another. Even if they've never been pregnant, if they've had an eating disorder...it is not embarrassing because they know, they've been there. (Donna, 4.1).

Participants also commented on the lack of available literature resources:

> Well, I know I would have felt better even if I could have picked up even a pamphlet or a booklet on that. Or at least know that there's enough people out there that deal with it that I am not alone. (Donna, 4.1).

> I am not super big on groups and stuff, like AA twelve step stuff and all those others but I do believe they probably work for some people. I would have found it helpful for me, though, to have something to read that talked about it. I find reading really therapeutic and even more so when it relates to me. I would have found comfort in knowing that I'm not the only one. (Jessica, 10.1).

All of the participants in this study reported that the presence of supports systems were of prime importance and for some women it made the difference between engaging in positive versus negative protective behaviours. It was also evident that there was a definite lack of available resources for these women, particularly in relation to pregnancy.

## Making the Transition to Parenthood

Although the focus of this research study was to explore and describe participants' experiences with eating disorders during their pregnancy, it became clear during the interviews that the transition to parenthood was also a major concern for these women. Becoming a parent was viewed as a significant responsibility by the participants. It was also viewed as an extension of the pregnancy as they still had to make decisions with respect to protecting the self or protecting the baby. The participants stories of making the transition to parenthood will be shared from both the "at the hospital " and "at home" experience.

### At the Hospital

The participants describe the highlight of their hospital experience as being breastfeeding. Breastfeeding allowed some participants to stay in hospital for an extended period of time:

> ...they let me stay for four days and let me kind of get my feet wet...and they helped me a lot with breastfeeding and I was able to kind of keep eating. (Bonnie, 2.1).

> I chose to nurse...I really wanted to nurse J. because I thought it was the right thing to do and...I thought it would do a good bonding thing for us because my mother-daughter relationship wasn't good. (Bonnie, 2.1).

> I stayed in for an extra day because I was breastfeeding M. and was having problems. I guess that worked out OK because I felt like it gave us a good start. (Carol, 3.1).

Breastfeeding was also a motivating factor for participants to keep eating:

> ...tried to keep in mind that you still keep eating for the purpose of nursing. Otherwise you will lose your milk, so I won't be able to nurse. So I was kind of doing it for the outside gain. (Bonnie, 2.1).

> I knew I had to keep giving myself at least something little to eat because he was depending on me. I made sure though that I drank a lot of water because I was told I had to keep hydrated. Water doesn't have any calories so I thought that was all right...but don't get me wrong, I did eat a little too. (Jessica, 10.1).

Bonnie found it difficult when her daughter stopped breastfeeding:

> It's when she quit nursing...then I had to go through this whole thing, 'well, I have to continue to eat now...so that I stay healthy enough so that I can look after her'. So again it was for J. (Bonnie, 2.1).

The hospital experience was reported to be "rushed" by many of the participants but they generally felt supported by hospital staff during that time:

> I felt like there was a lot that I needed to learn but my nurse reminded me to keep it simple for myself...and that was the best advice ever. I did learn everything I had to, but certainly not before I left the hospital...she told me to trust in myself and that things would be OK. Somehow that reduced my anxiety and I just focused on dealing with the basic needs...like feeding me and feeding my baby. (Ginny, 7.1).

## At Home

Several of the participants described feeling fearful and anxious once they were home from the hospital. Much of the initial anxiety and fear experienced were anticipated maternal adaptations to the postpartum period. However, for the participants in this study, the fear and anxiety had deeper meanings and implications and centred predominantly around parenting.

### Parenting

For many participants, the idea of parenting is met with apprehension and feelings of not being a "perfect mother" or a good role model, especially given their own family history:

> It's just that I don't know what's normal and not normal and I didn't have a normal childhood so there's nothing to base normal on....it's very frightening for me and I get really quite anxious about the whole thing. (Bonnie, 2.1).

> I want to be an ideal parent for her, you know...perfect, but I know that that's not always possible. I cannot even pull from my own experience...I mean of what it was like growing up in my home because I don't want it to be like that for her...I want her life to be normal--whatever that means. (Hope, 8.1).

The nature of parenting is difficult and stressful at times. For several participants, this additional stress adversely affected their eating disorder:

> ...when there's been too much happening, like too much stress, too many changes...and needing support and that kind of stuff can trigger...like last year I was having a hard time being a parent...still am...well, what's good parenting? what's bad parenting?...how I fit into all of this and that set me back...I was starting to go and I could feel it....My emotions are running really high and I cry a lot. I go through periods where I don't feel like I belong, kind of things, so I become very self-destructive, I guess. (Bonnie, 2.1).

> Sometimes I find it very stressful, and exhausting. I feel like I don't have enough energy to begin with, and then having the baby is stressful, and having to lose weight is stressful so I focus on not eating which used to make me feel in control. Now I just get more tired, actually exhausted and I feel less able to cope with being a good parent. It's a vicious circle and I don't know how to stop it. Having to be in control of my emotions without not eating is really difficult for me but I also don't want to release my stress with snapping...I can't do that to my baby either. (Carol, 3.1).

> Yeah, I get really stressed out sometimes. I have work, my family, the baby...I feel like I need a break but I can't always get one. Dealing with all the demands on me usually means I stop eating...then comes the headache, and then I have to lie down so that I don't get a migraine...and this happens over and over again. There has to be a weak link there someplace where I can break this cycle I am in. (Jessica, 10.1).

Participants were faced with new challenges and difficulties as their children were growing up and learning to assert themselves and express their independence. Participants also discovered that their children were increasingly more aware of their coping behaviours:

> ...so that has been the hardest part because suddenly she has gotten older and now I'm having to try and do it for just me, more or less. It's difficult but for the past three years and about six months I have eaten every day...at least three meals a day and I have two snacks. (Bonnie, 2.1).

> ...one day...well, K. [daughter] woke up way too early and I was trying to do my exercises before she woke up or otherwise it's not too easy and I thought well, she sees me exercising during the day and she sees me now and she's going to see me at night. I don't want her to think this is normal...because I know it's not but I don't want her to end up like that or being obsessed about it. (Abby, 1.1).
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> My children remind me now when it's time to eat. When they were young we sometimes just went without eating because often I wouldn't even think about food, now they know that mommy never eats so they remind me that they are hungry and "we" need to eat. I fear for their eating... (Jessica, 10.1).

For the majority of the participants, there were concerns expressed about the eating habits of their children. Many participants were concerned about their own children's shape, size, and weight. There also were concerns expressed relating to the fear that their children would adopt their own preoccupation with body shape and weight as a result of growing up with a mother who has an eating disorder:

> I worry a lot about what he is eating and if he is getting too much or too little. I hate being paranoid about it but I don't want to have a fat kid...I also don't want to have a really skinny kid that can't do anything. I just want him to be healthy but I am not sure if he is eating the right amount. (Carol, 3.1).
>
> I try not to get too hung up on how much they are eating but sometimes it's hard. I am so careful about what I eat and then I see that my children like to eat junk like chocolate, and candy and stuff...and everytime I see them putting it in their mouths, I can't help but to calculate how many calories they just consumed and how much exercise they will need to burn it off. (Francis, 6.1).
>
> I am probably overly concerned about her eating, or shall I say not eating. The girl rarely eats but it doesn't seem to be because she is preoccupied with her weight or anything, she is just playing all of the time. I want her to just eat when she is hungry but I find myself almost making sure that she eats because I don't want her to ever go hungry...to starve the way I have sometimes. I keep in check with her though and try to tell her how beautiful she is on the inside--not just the outside. That's what was missing for me. (Bonnie, 2.1).

It appears as though in their roles as mother, the participants' fear of food and intense preoccupation with body shape, size, and weight directly conflicts with the responsibility to feed and nurture her child. Once again, the process of protecting comes into play. Protecting for one participant meant not have any more children due to the eating disorder:

> I'm not going to have any more children. I have decided to actually have a laporascopic sterilization...I don't think that it's because I fear gaining more weight and having that baby. It's because I fear the depression and I fear the slides...the time periods when things

> are too rough and I start restricting and doing bizarre eating behaviour. I want to be there for J. I chose to have her. If I have 2, 3, 4 kids, how far will I be able to spread myself. For me...having her is enough. I went through a very hard time last year parenting and was very afraid. I had...we got Catholic Social Services involved because they were so afraid I was going to hurt her or hurt myself. I think this would be really important. I don't know if it's for everybody but for me...when my baby went from being a baby and nursing to being this little person and starting to talk and having an opinion and telling me off and getting control...I was totally afraid. I thought, 'Oh no, I can't do this anymore'. When she was an infant, I had control....I was still mom and I was being able to nurture her and look after her...and suddenly she was breaking away into that independence thing and I got...I was scared. I still am scared. (Bonnie, 2.1).

***Of all of life choices,***
***none are more important to society,***
***none has more far reaching consequences,***
***none represents a more complete blending of social,***
***biological, and emotional forces***
***than bringing another life into the world.***
***Victor Fuchs***

## Engaging in Protective Behaviours

The action of seeking reassurance, the interaction of stressors, and factors such as fear, uncertainty, guilt, body image, motivation, support, and making the transition to parenthood on the assessment of perceived risk to the health of the baby versus the perceived threat to self-image, all significantly impacted and lead to the participants' engagement in protective behaviours. The protective behaviours engaged in may be negative or positive on the protecting continuum (see Figure 1).

Those behaviours which were negative in nature were the actions or behaviours which the participant engaged in as a result of perceiving some threat to their self-image as a thin person. This perceived threat to self-image moved the participant in the direction of "Protecting Self-Image" on the far left of the protecting continuum. The motivator at this point on the continuum was the pursuit of thinness.

Those behaviours which were positive in nature were the actions or behaviours which the participant engaged in as a result of perceiving some risk to the health of the baby. This perceived risk to the baby moved the participant in the direction of "Protecting Baby" on the far right of the protecting continuum. The motivator at this point on the continuum was having a healthy baby. The protective behaviours that the participants engaged in are those which addressed the negotiation of nutrition in pregnancy. This will be further explored in text and may also be viewed in a schematic model (Figure 4).

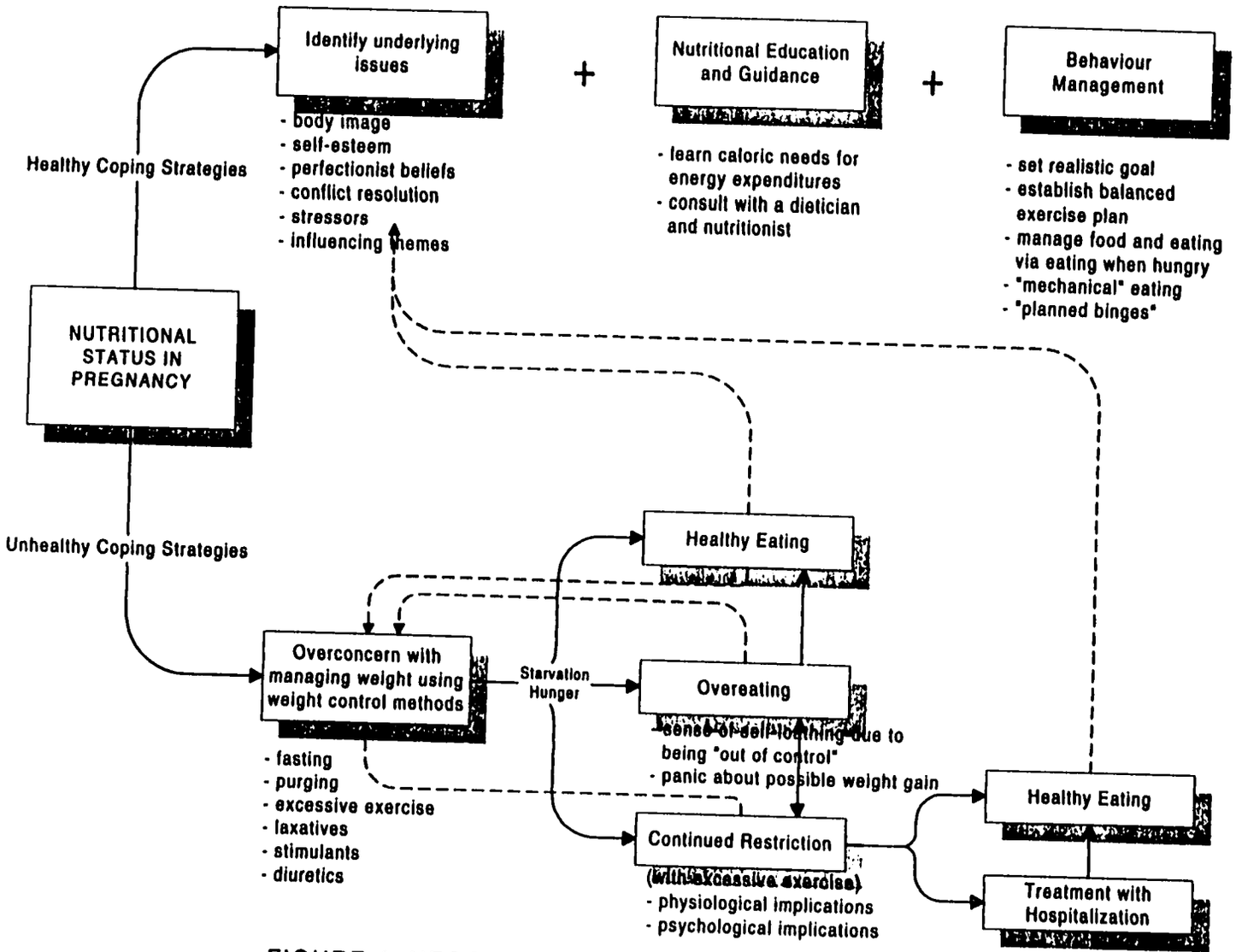


FIGURE 4: NEGOTIATING NUTRITION IN PREGNANCY -- COPING STRATEGIES

## Negotiating Nutrition in Pregnancy

The participants engaged in protective behaviours that either directed them towards healthy or unhealthy coping strategies. The healthy coping strategies or positive behaviours were those strategies that optimized nutritional status in pregnancy thus moving towards protecting the baby, or having a healthy baby. The unhealthy coping strategies or negative behaviours were those behaviours that did not optimize nutritional status in pregnancy thus moving towards protecting thinness. Healthy coping strategies will be addressed first followed by the unhealthy coping strategies.

### Healthy Coping Strategies

The healthy coping strategies are those behaviours which encourage optimal nutritional status during pregnancy for women suffering from eating disorders. This optimal state is reached via the incorporation of three events: the identification of underlying issues; nutritional education and guidance; and behaviour management. These three events will be discussed as they relate to the participants in the study.

#### Identify Underlying Issues

In order for a woman to begin to engage in positive healthy behaviours, she must first begin to identify some of the underlying issues or problematic areas that she may be experiencing. Data has been presented which show that it was these underlying issues which the women were trying to subconsciously suppress through their eating disorder behaviour. When these underlying issues are identified for a woman, the process of healing and recovery may start. That is, she begins to deal with the underlying issues as opposed to dealing with her eating disorder. As was evident from the stories shared by participants earlier in this chapter, this identification and exploration of underlying issues is a rather painful and difficult process to undertake. The key underlying issues that were identified by the participants and which have been described included: body image; self-esteem; perfectionist beliefs; conflict resolution; and perceived stressors.

#### Nutritional Education and Guidance

One healthy coping strategy is that of seeking nutritional education and guidance. For all of the participants who had disclosed their eating disorders to their health care provider, a nutritionist was made available to them throughout their pregnancy. For those participants who did not disclose their eating

disorders, nutritional information was obtained through prenatal classes and "brief" discussions about diet with their health care provider.

> I go to see the dietician...I see her everytime I go for an appointment...whenever I go to see her I tell her how I've been doing...(Abby, 1.1).

> I thought I should go see a dietician...helped me a lot with that and I was able to keep eating. (Bonnie, 2.1).

> I mean, I took prenatal classes and stuff so...they covered the nutrition thing there. (Donna, 4.1).

Most women suffering from eating disorders have a solid knowledge base and thorough understanding regarding caloric needs and expenditures. For many this equation, (energy in = energy out), is how they have lived their lives for many years so understanding the added requirements during pregnancy was not difficult for the participants. They were encouraged by their health care providers, nutritionist, or dietician to follow the guidelines on the Canada Food Guide (Appendix I) or follow a particular plan that was set up for them by the nutritionist.

**Behaviour Management**

With the combination of having identified underlying issues and received nutritional education and guidance, behaviour management had a solid foundation on which to begin. For the participants who engaged in behaviour management either with the assistance of a health care provider or independently, the management consisted of setting a realistic goal, establishing a balanced exercise plan, managing food via eating when hungry, mechanical eating, and utilizing planned binges.

**Setting a realistic goal/Establishing a balanced exercise plan**

Setting a realistic goal was difficult for participants. Most were used to setting goals in relation to weight loss. In order to engage in positive behaviours during pregnancy, their goals were no longer measured in terms of pounds but rather in amount of food intake and energy expenditure.

> It was really hard but I knew that each day my goal was to eat three meals and try to have three snacks a day. In my mind I kept thinking that I was gaining weight and stuff but I kept struggling with not thinking about how many pounds this, or how many pounds that...my goal was to eat each and every day. (Carol, 3.1).

> N. [the dietician] had set up for me a program and...I still have a hard time even going up to that standard. Like at the end of my pregnancy I didn't gain weight, for over a month I didn't gain weight at all. They did a biophysical to see if the baby wasn't growing. She was growing but I just wasn't gaining any more....I ate what I guess would be considered very healthy. (Bonnie, 2.1).

> I have the energy in/energy out thing down to a science. I used to run marathons...and will again, so I found not working off all my caloric intake really difficult. I didn't know how to account for the baby and I didn't want to deny the baby any food so it became a real struggle. I guess my aim was not to overdo it with exercise like I have a tendency to do. (Francis, 6.1).

**Managing food/Mechanical eating/Planned binges**

Managing food and nutritional intake by eating when hungry was difficult for the majority of the participants. Only one participant describes knowing her body well enough to eat when she knows that her body needs to eat, and not because it is reaching a state of starvation:

> I now know when my body is hungry and needs to eat. It took a really long time for me to find that point but I think I have it. Now I eat when my body tells me it's time to. I am somewhat on a schedule now. It wasn't always like that but I guess I put my body on some sort of "basic training" course in order to reach this point. (Eva, 5.1).

Some participants ate simply because they knew they needed to, and not always with a plan:

> ...and you are supposed to drink a lot of milk when you are pregnant for whatever reasons and that was the one food thing that I associated with eight billions of calories and could not drink. I had to force myself to drink skim milk. (Donna, 4.1).

> I was eating...but I was...I wasn't one of those people who think 'Ah ha, right I'm pregnant' and then you eat cake and chocolates and then just go gung-ho. I was eating but I was eating a very healthy restricted diet. (Bonnie, 2.1).

> For a little while there was no method to my madness. I just knew that I had to eat something little, just to keep me and the baby going...mostly the baby because I knew that I could do without. (Jessica, 10.1).

For the rest of the participants who engaged in behaviour management, their technique was to manage their nutritional intake using planned or "mechanical" eating:

> Well, I have breakfast and lunch and supper and then I try to have a snack whenever and one before I go to bed...and then I have this chart that you hang on the fridge with the

> markers and you check off how many dairy products and proteins and cereals and breads and vegetables and fruit you have in a day...and make sure you have at least three dairy products and two proteins--meats and stuff like that. (Abby, 1.1).
>
> ...I'll even get it to where I'm eating more like two meals a day and a snack...it's still not a lot by most standards probably but for me it's definitely good. (Donna, 4.1).

One participant managed her previously "out of control" binges by "planning" her binges during her pregnancy. Although it was not a totally healthy coping behaviour, for her it was the best compromise available. The alternative would be for her to remain "out of control" with her binges:

> I know that it wasn't great but it was the best that I could do at the time. My binging and purging was so out of control that sometimes I made myself sick eight, nine, ten times a day...my guts, my jaw, everything about me hurt...and I was so worried about the baby, I knew that I had to stop...I couldn't do that "all or nothing" thing so we worked out planning or, I guess allowing myself the freedom to binge, like...once a day, and eventually it was once every two days, and...that worked for me. (Ginny, 7.1).

Some of the participants who engaged in protective behaviours that were categorized as healthy coping strategies occasionally slipped into unhealthy behaviours using methods of weight control that had "worked" for them in the past.

**Unhealthy Coping Strategies**

Unhealthy coping strategies are those behaviours that discourage optimal nutritional status for women experiencing eating disorders during their pregnancy. These unhealthy coping strategies are those which direct women towards protecting their self-image or the pursuit of thinness. For the participants, the pattern of unhealthy coping strategies consists of the overconcern with managing weight using weight control methods which then leads to a condition of starvation or hunger. The participant then chooses either to eat in a healthy way, overeat, or continue to restrict their intake. If the participant chooses a healthy diet, she moves in the direction of healthy coping strategies; if she overeats, she tends to move towards restriction of intake; and if she restricts initially, she moves towards choosing to eat healthily whereby she demonstrates healthy coping strategies. She may also be hospitalized for a progressive starvation condition. Participants can move towards healthy eating at any point in the process.

**Overconcern with managing weight**

Participants who utilized unhealthy coping strategies as a result of feeling a threat to their self-image, demonstrated an overconcern with managing their weight using weight control methods such as fasting or restriction, purging, excessive exercise, and the use of laxatives, stimulants and diuretics. These methods of weight control were commonly used by participants throughout their eating disorder experiences. This overconcern with managing weight using weight control methods produced a state of hunger or starvation which, in turn, lead to participants choosing between three behaviours: (i) eating healthily, (ii) overeating, and (iii) continued restriction.

**(i) Healthy Eating**

Those participants choosing to eat healthily began engaging in protective behaviours that supported having a healthy baby. They began utilizing healthy coping strategies:

> I had to eat regularly, according to a schedule that I had up on my fridge...this way I knew that I was feeding the baby and myself. (Abby, 1.1)

**(ii) Overeating**

Some of the participants engaged in the behaviour of overeating which then led them to feel a sense of self-loathing due to being "out of control" of their eating. They also began to feel panic about the potential for resultant weight gain:

> You know when you get that real "vacuum-gut" feeling and you can't get enough to fill the vacuum. Well, that's how it feels...and as soon as I fill my face I want to be sick...not just sick to my stomach because I feel so full...I feel sick of myself. I hate that out of control feeling...not at the time 'cause when I am eating I feel euphoric, it's after...that's when I really hate myself. Then I think, 'Oh God, now I'm going to gain all this weight' so I stop eating again. (Ina, 9.1).

When the participants engaged in overeating, the majority then chose to restrict their intake to decrease the impact that their recent binge had on their weight.

**(iii) Continued Restriction**

Continued restriction was the most utilized coping strategy for those participants who were pursuing the desired state of thinness. Many of the participants combined excessive exercise with restriction in order to accelerate the weight loss goal. During this time, participants had nutritional intake of little to nothing at all. This usually became cyclical whereby they would either eat healthily or overeat and then restrict again:

> ...other times I go, 'I don't know what I'm going to eat next, I don't know what I'm going to let myself eat next. It could be a week, it could be an hour, it could be two days, you never know...and you kind of...you're always anxious because you never know when you are going to let yourself have anything to eat again...when you're pregnant, you know, well, 'well, I have to have this and I have to have at least that during the day', so you know that you are not going to be totally starving yourself. (Abby, 1.1).

> I usually didn't eat until about three o'clock and then I would have some tea and maybe a melba toast and a few carrots. That pretty well filled me up...when I was home from work I just went to bed 'cause my head hurt so bad. (Jessica, 10.1).

> ...where for like a week after beating myself up mentally because I haven't eaten anything and that's bad for the baby so for after about a week of it I'll say, 'you can't do this anymore--you'll have to start eating at least once a day'. So I will and I'll be good for a couple of days and then...I'll turn around and say 'Oh, I shouldn't eat that, that was too many calories', I can't really exercise too much anymore at this point so I can't burn it off. I'm not burning it off so I go, 'I better not eat!'. So I stop again. (Donna, 4.1).

Continued restriction carried with it both physiological and psychological implications for the participants. If the participant continued to restrict, the options at that time would be treatment with hospitalization at one extreme, and eating healthily at the other extreme. Three of the participants were threatened with hospitalization should their eating behaviours not improve. They weighed the alternatives and chose to practice healthier behaviours which resulted in no hospitalizations during their pregnancy.

## Summary

The participants utilized various coping strategies to negotiate their nutritional status in pregnancy. The strategies or behaviours which were positive and healthy were those which the participants engaged in in order to pursue having a healthy baby. The strategies or behaviours which were negative and unhealthy were those which participants engaged in in order to protect their self-image from psychological harm (protection from having to face the underlying reasons for their behaviours) and also those which enabled the woman to pursue a state of thinness.

The outcome of the process of protecting was the birth of the baby. For all of the participants of this study, the outcome was a healthy baby despite where the participant was on the continuum of protecting self-image or protecting baby. Many participants danced with the extremes at times during their pregnancy, but the majority of participants seemed to vascilate somewhere in the middle or more to the right as a result of being motivated to have a healthy baby. It was determined that the movement towards protecting self-image and/or protecting the health of the baby continues far beyond the birth of the baby. For women with children, the process of protecting never ends.

The participant's life stories suggest that the relentless pursuit of thinness is not a uniform phenomenon but is influenced by different life situations and circumstances. This pursuit may be lived in a variety of ways. However, optimism and hope endures as many women are opening themselves up to telling their stories which appears to be a necessary step for the healing process to occur. This healing process has, in part, empowered the women in this research study to meet the challenge of protecting their unborn children and learning healthier ways of coping with their own protection of self-image.

***And now here is my secret,***
***a very simple secret;***
***it is only with the heart***
***that one can see rightly,***
***what is essential is invisible to the eye.***
***Antoine de Saint-Exupery***

# CHAPTER V

## CONCLUSIONS, DISCUSSION, AND IMPLICATIONS

*All fuses now, falls into place*
*From wish to action, word to silence,*
*My work, my love, my time, my face*
*Gathered into one intense*
*Gesture of growing like a plant.*
*May Sarton*

The purpose in this study was to explore and describe the personal experience for women of having an eating disorder during pregnancy. In this chapter, the findings will be discussed in relation to the existing research and the research questions. A survey of published work related to eating disorders was presented from a biomedical, psychiatric, and feminist perspective. The feminist approach offered the broadest perspective and will also be utilized in the discussion of the findings. Next, propositional statements derived from the findings will be presented. The strengths and limitations of the study will be discussed. Implications for health care professionals relating to education, clinical practice, and research will be addressed and a brief exploration of ways in which barriers can be overcome will then be presented. A brief summary completes the chapter.

### Conclusions

The women who participated in this research study were able to clearly identify and articulate their perceptions of and experience with an eating disorder during their pregnancy. The research findings will now be summarized as they relate to the research questions.

In relation to the research question **'What is the experience of women who have an eating disorder--anorexia nervosa and/or bulimia nervosa during pregnancy?'** it was found that the main theme emerging from the data in this study, namely **Protecting**, centres around the way in which women who have an eating disorder during pregnancy protect either their own self-image as a thin person or the health of their baby, or a combination of the two (see Figure 1). Protection exists on a continuum between

two competing motivators: (i) the health of the baby and (ii) the pursuit of thinness. The women, therefore, spend much of their pregnancy in conflict between these two competing motivators.

Where a woman places herself on this continuum is contingent upon how she perceives the threat to self- image versus the risk to the health of the baby. This personal risk assessment influences the depth to which women seek reassurance from others and whether they engage in protective behaviours of their self-image and/or the health of their unborn baby. Self reassurance occurs throughout the pregnancy, and varies in intent depending upon where the woman lies upon the protecting continuum.

- A woman's ability to protect is also influenced by identified factors which are enmeshed within the process and are both internal and external in nature. These factors are identified as: fear, uncertainty, guilt, body image, motivation, support, and making the transition to parenthood. Their interaction with the process of protecting focuses on the strategy of assessment of perceived risk to the baby versus the perceived threat to self-image.

The movement towards one or the other competing motivators on the continuum is also dependent upon how the woman interprets and internalizes the stressors in her life. If the stressor is perceived as a threat to her self-image, she will move more towards protecting her self-image whereas if the stressor is perceived as a risk to the health of the baby, she will move more towards protecting the baby.

The engagement of protective behaviours, namely the negotiation of eating and nutrition during pregnancy, takes place following risk assessment and is also a response to the stressor experienced. The negotiation of eating and nutrition contributes to the placement of a woman on the protecting continuum.

Clearly the answer to this research question is complex and involves the interaction of many different influencing factors. A women experiences a great deal of conflict during her pregnancy. The process of protecting helps to provide insight into the womens' experience with having an eating disorder during their pregnancy. There may possibly be more to this process than this preliminary research can answer.

The second research question posed was: **'How do women with eating disorders --anorexia nervosa and/or bulimia nervosa--negotiate eating and nutrition in their pregnancy?,** it was found that women in this study utilized various coping strategies to manage their eating disorders during

their pregnancy. These coping strategies can take both healthy and unhealthy directions and are influenced by stressors a woman may experience during her pregnancy. A negatively interpreted and internalized stressor directs women towards protecting her self-image as a thin person. A positively interpreted and internalized stressor directs women towards protecting the health of the baby. If a woman is in an emotional state of protecting her baby, she will seek out healthy strategies for maintaining optimal nutritional status. This involves identifying problematic areas, nutritional education and guidance, and behaviour management. However, if a woman is in an emotional state which is that of protecting her self-image--or the pursuit of thinness--she will utilize unhealthy strategies, namely food restriction, with the intent to be thin. These unhealthy strategies lead to a path of starvation with subsequent responses of either healthy eating, overeating, or continued restriction. If a women chooses healthy eating, she then begins to utilize the healthy coping strategies. If she responds by overeating, she tends to experience self loathing due to being "out of control" and usually acts by restricting her eating. If she moves directly to continued restriction, she most often is threatened with hospitalization or eating healthily. The fear of hospitalization is so strong that typically women will respond by temporarily eating healthily.

The negotiation of the nutrition path is also complex and is largely dependent upon the action/interaction strategies of seeking reassurance, assessing risk to the health of the baby versus the threat to self-image, influencing factors, and stressors. A woman may change her path many times throughout her pregnancy and this appears to be largely dependent upon the action/interaction strategies. This finding is crucial in that if health care professionals can target, embrace, and influence the positive stressors and influences in a woman's life, a woman may respond by engaging in protective behaviours that support having a healthy baby without leaving her feeling personally threatened. This strategy would involve intense interaction between a woman and her health care provider, but the potential positive response is well worth the energy for both mom, baby, and society in general.

## Discussion of the Findings

### Development of an Eating Disorder

For all of the women in this study, their eating disorder long preceeded their pregnancy. A brief exploration of the development of the eating disorder for the participants was of importance in order to fully understand the dynamics and complexities which the eating disorder brought to the pregnancy. The development of the eating disorder was clearly an antecedent to the womens' experience of eating disorders during pregnancy.

There were predisposing and precipitating factors that led to the development of an eating disorder for the participants. The predisposing factors were sociocultural, psychosocial, biological, and personal. All of the factors were interrelated and all contributed to the complexity of the developing eating disorder. The predisposing factors were then impacted by stressors, or precipitating factors, which included victimization, abandonment issues, the breakdown of family relationships, peer influences, and major life changes. Every participant experienced a minimum of one stressor prior to the development of their eating disorder. There is not one theory agreed upon by scholars that explains the development of an eating disorder. However, it appears that to understand the development of an eating disorder for these women, a combination of many theories needs to be used.

### Predisposing Factors

The four predisposing factors which contributed to the development of the eating disorder were categorized as sociocultural, psychosocial, biological, and personal.

#### Sociocultural Factors

All of the women in this study desired to be thin and experienced an intense fear of gaining weight or becoming fat despite being underweight. This is one of the criteria used for the diagnosis of anorexia nervosa (American Psychiatric Association, 1994). The participants felt pressure to conform to society's ideal of the acceptable woman and subsequently began to diet and exercise intensively. This pressure existed at an early age for the participants given that their eating disorders are reported to be present from as early as eleven to seventeen years of age.

The relatively young age at which eating disorders become a reality for women has been reported previously. There are also many studies of body shape preferences in normal and eating disordered adolescents and women. Collins (1991) undertook research on pre-adolescents to determine their body figure perceptions and preferences. The researchers found that girls selected pictures depicting thinner figures than did the boys for the child who had the "ideal" figure of "the way you want to look". The researchers also found that 25% of the thinnest girls as measured by body mass index, preferred figures that were even thinner. These findings are consistent with adult and adolescent preferences in both normal and eating disordered females and demonstrate that sociocultural norms and values effect children at an early age (Thompson & Dolce, 1989; Fallon & Rozin, 1985).

Dieting for the participants in this study consisted of minimal nutritional intake to no nutritional intake at all for prolonged periods of time. The subsequent weight loss experienced reinforced the dieting behaviour. The pattern of dieting behaviour has been associated with a risk for the development of eating disorders either by setting up binging or by its relationship to society's norms of the ideal body shape (White, 1992). Apart from diet and exercise, other weight loss methods utilized were stimulants, diuretics, purging, laxatives, and smoking cigarettes. These weight loss choices are consistent with those used by the majority of women who experience eating disorders (MacDonald, 1996).

When the participants lost weight, they received positive reinforcement to continue their behaviours since significant others rewarded them emotionally by providing them with attention resulting from their weight loss. When the weight loss became too severe, they continued to receive reinforcement as individual's commented on their excessive thinness.

The researcher explored the choice of profession as a potential risk factor to having an eating disorder. Professions that promote personal appearance and weight standards are dancers, airline flight attendants, athletes, actors, and models (McKenna, 1989). None of the participants of this study fit within this group, however, it is important to note that three of the ten participants had portraits of ballerina's displayed in their homes.

It has also been noted that women are more at risk for eating disorders if they are white, middle or upper class, and come from high achieving families (Schwartz, Thompson, & Johnson, 1992). All of the

women in this study were Caucasian, middle to upper class, and reportedly came from high achieving families.

**Psychosocial Factors**

Common to all participants was a family-of-origin that had difficulty dealing with stress, managing and resolving conflict, and expressing emotions. Most often participants were in conflict with their mothers. The mothers of the women in this study were reported to be dominant, strict and rigid. The fathers of the women in this study were not discussed separately apart from their role as "parent".

There are authors who consider eating disorders to be a symptom of a dysfunctional family (Leung, Schwartzman, & Steiger, 1996; Minuchin, Rosman, & Baker, 1978; Palazzoli, 1978; O'Kearney, 1996; Kog & Vandereycken, 1989; Strober & Humphrey, 1987). One of the earlier theoretical works on families of eating disordered women was Munichin et al.'s (1978). They hypothesized that such families possessed the specific characteristics of being enmeshed, avoiding conflict, being overprotective, and having rigid boundaries.

With respect to the mother-daughter relationship, it has been noted that separation-individuation from one's mother is more difficult for girls and this conflict persists much longer than for males (Beattie, 1988). Many of the women in this study continued to struggle with their relationships with their mothers. It has been suggested that the result of this conflict at an early age is disordered eating which serves as a coping mechanism for feelings of separation from one's mother (Zakin, 1989). Zakin's findings are also supported by earlier research (Masterson, 1977; Palazzoli, 1978).

Seven of the participants linked their relationship with their mother to their eating disorder. Those women who reported having a strained relationship with their mothers also reported experiencing a worsening of their eating behaviours when they felt increased stress or strain with their mother-daughter relationship. The mothers of the participants were in denial of their daughters eating disorders. According to Wooley and Wooley (1986), most parents of bulimics are terrified by their daughter's condition. This could lead to either parent denying their daughter's eating disorder. Despite societal and familial patterns, consideration should also be given to dilemmas faced by daughters and mothers in getting along with each other. These conflicts are timeless and relatively independent of culture (Zerbe, 1993).

The participants in this study believed they needed to be "perfect" children in order to be accepted in their families. The pursuit of perfection is considered common to women in general since women are more concerned with their body image and appearance than men (White, 1992). Participants were "striving to be perfect" which meant a perfect body, by shape or weight. They entered into a cycle of striving to be perfect which involved being thinner, weighing less, or being more toned. They expected and received approval for their behaviours thereby establishing the cycle. Steiner-Adair (1986) studied the "superwoman" ideal and related her to symptoms of eating disorders in adolescents. Adolescents were vulnerable to the norms and expectations of our society that are achievement and perfection oriented. Other researchers have also found that high achievement and success is more emphasized by mothers of eating disordered patients. The mothers of the women in this study were also found to be controlling and domineering (Sights & Richards, 1984).

The women also believed that their home environment contributed to their eating disorder. This is supported by Leung, Schwartzman, and Steiger (1996) who postulate that family environment may enhance vulnerabilities to eating and psychiatric disturbances through: (i) the family's preoccupation with weight and appearance which contributed directly to the development of body dissatisfaction and to eating symptoms, and (ii) the dysfunctional family relationships which contributed directly to development of negative self-esteem and to eating symptoms. This is consistent with previous studies which indicate the family's contribution to the development of an eating disorder (Pike & Rodin, 1991; Rodin, Striegel-Moore, & Silberstein, 1990).

In this research study the family backgrounds of anorexic and bulimic women were not differentiated. However, researchers suggest that the families of anorexic women report greater cohesion (the degree of commitment, help, and support that family members provide one another) and inability to deal with conflict (avoiding open expression of anger or aggression) whereas the families of bulimic women report more conflict (as opposed to conflict avoidance), were more disorganized, and uncohesive (Kay & Vandereycken, 1989; Ordman & Kirschenbaum, 1986). It appears that anorexic family characteristics may differ from bulimic family characteristics.

In summary, dysfunctional family relationships were identified as a factor which triggered the eating disorders for women in this study. Dysfunctional factors included overprotectiveness, most often by the mother, conflict avoidance or open conflict, achievement and success orientations, strained mother-daughter relationships, and rigid boundaries.

**Biological Factors**

The participants in this study all believed that their eating disorders were related to their being female. There is some suggestion that there is a relationship between increased body fat at puberty and the development of anorexia nervosa. Those who support this theory also report that dieting and starvation are prominent behaviours prior to the development of the eating disorder (Boskind-White & White, 1983). For the participants in this study, there was some suggestion that they felt fat prior to their eating disorder however when discussing this further they reported that this is how they felt, not necessarily that they were "fat". Dieting and starvation were symptoms prior to the development of their eating disorder which supports Boskind-White and White's theory.

The imbalance of neurotransmitters serotonin and norepinephrine as well as melatonin and decreased secretion of cholecystokinin have recently been postulated as possible causative factors in the development of eating disorders (Kaye & Weltzin, 1991). There may, indeed, be a biological link for the development of eating disorders, however very little research has been done in this area and this linkage went beyond the parameters of this study.

**Personal Factors**

The personal factors which influenced the eating disorder behaviour included personal attitudes toward eating, food, and body; self-esteem; body image; lack of identity; and coping skills. These personal factors were intrinsic in nature but they were created as a direct result of extrinsic forces such as the sociocutural forces and personal environment in which the participant was raised. The personal factors were a direct result of external pressures to belong within our society, and these pressures often reached so deep within an individual that the individual began to believe in them herself. The eating disorder became the participants way of coping with the incongruence she felt between society's expectations of the ideal female,

and the participants perception of her real self. Conflict is also experienced as a result of a changing society's ideals and which of those ideals should be incorporated by the woman.

For one participant, personal factors included her diagnosis of scoliosis. This diagnosis contributed to her disruption of a positive body image. A woman's perception of her body image may be in conflict with the current societal ideal of a slender, toned physique. This conflict is particularly sensitive around the time of adolescence when curves and breasts begin to develop and fat increases (Bordo, 1990). It is during this time that the adolescent female needs to feel accepted. For the participant with scoliosis, there was additional stress placed on body image and therefore she experienced increased discomfort and difficulty with being accepted by her peers. Since she could not control the diagnosis of scoliosis, she chose to control her eating which meant increasing her chance of acceptance by others since she would portray society's ideal "slim" physique. Her eating disorder was her way of coping with being "different" and of gaining acceptance in whatever way she could.

One of the study participants was diagnosed with Obsessive Compulsive Disorder (OCD). Five of the other participants also refer to some degree of compulsive behaviour in their lives. Recent research suggests that obsessional personality traits and symptoms occur in 3 to 83% of eating-disordered cases (Thornton & Russell, 1997; Kasvikis, Tsakiris, Marks, Basoglu, & Noshirvani, 1986). Two other potential psychiatric conditions which were reported by study participants (although undiagnosed) were depression and anxiety. Research studies over the past decade have supported the association between eating disorders and other psychiatric conditions such as anxiety and depression (Zerbe, 1993).

## Precipitating Factors

Precipitating factors were stressful events that served as an additional trigger towards the diagnosis of an eating disorder. These included victimization, abandonment, the breakdown of family relationships, perceived lack of attention, peer influences, and major life changes.

### Victimization

Victimization was a common experience for nine of the ten participants. It appeared to be the most significant precipitating factor to the development of the eating disorder. Of the ten participants, six reported a history of sexual abuse which also involved physical abuse. Three reported a history of physical

abuse, while only one participant had no memory of any abuse in her history. None of the participants reported being emotionally abused. It is reported that 50 to 65% of all eating disordered patients report a history of physical or sexual abuse (Bulik et al., 1989; Jacobson and Herald, 1990; Palmer et al. 1990).

Participants who were sexually abused as children tended to become sexually active and promiscuous at an early age, around the same time that they report their eating disorder beginning. The women who were sexually abused also experienced a disassociation with their own body parts, for example their breasts, which were associated with femininity and sexuality. The women tried to suppress a change in their shape through their eating believing that this would decrease the abuse.

There has been considerable research related to the relationship between sexual abuse and eating disorders (Everill & Waller, 1995; Moyer, DiPietro, Berkowitz, & Stunkard, 1997; Pitts & Waller, 1993; Tobin & Griffing, 1996). Findings from a recent study by Zlotnik et al. (1996) showed an association between sexual abuse and a pattern of eating disorder symptomology for the 134 patients in the study. In addition, it was found that these patients obtained higher scores on the Eating Disorder Inventory (EDI) subscales of drive for thinness, interpersonal distrust, and perfectionism--all qualities common to the participants in this study. It is suggested that the elevation of these scores is indicative of an overconcern with diet, body weight, shape, and size and possibly that this is a defence against out-of-control feelings engendered by a violation of the body. The feeling of being "violated" was expressed by all of the participants in this study with a history of sexual abuse.

**Abandonment and Other Issues**

In this study, a link between abandonment and eating disorders was reported. In the literature, abandonment is linked to attachment disruption theory and eating disorders (Palazzoli, 1978; Masterson, 1977). Masterson (1977) reports that early mothering of the anorexic rewarded dependency and threatened emotional abandonment for signs of separation or independence. The result of this is a child with an overwhelming fear of abandonment and confusion in attempts to separate and individuate in adolescence. For the participants, abandonment was associated with the mother, but also with anyone having emotional significance for them. Abandonment was also associated with changes in location whereby the participant

changed homes and schools. Abandonment is clearly linked with a participants family-of-origin, once again reinforcing the influence of environment.

## The Process of Protecting

### Diagnosis of Pregnancy

The diagnosis of pregnancy came as a surprise to all of the participants in this study, including those five participants who had been planning to have a child. All of the women doubted their ability to conceive a child since none had a regular menstrual cycle. The absence or irregularity of menstruation for women suffering from eating disorders is common (Kaplan, 1990; Loucks, Vaitukaitis, Cameron, Rogol, Skrinar, Warren, Kendrick, & Limacher, 1993) and one which is used as a principal diagnostic criteria for anorexia nervosa (American Psychiatric Association, 1994). Amenorrhea in this group of women would imply anovulation which would therefore exclude pregnancy (Berry, 1991). The few reports describing eating disorders during pregnancy made no allusion to the presence or absence of menses before conception. Despite the absence or irregularity of menstruation for the participants, they did conceive.

Those women who were planning their pregnancy were aware that their chances of conception were lower than average. They altered their eating and exercise behaviours to increase their likelihood of conception. Since the participants were able to conceive after changes in behaviour, they attribute these changes directly to their success at conceiving a child.

The suspicion of pregnancy was not common for the participants. Those who planned their pregnancy suspected they were pregnant based on feelings such as breast tenderness and nausea which are commonly recognized as subjective signs suggestive of pregnancy (Cunningham, MacDonalds, Grant, Leveno, & Gilstrap, 1993). They were diagnosed as pregnant earlier on in their pregnancy than those women who did not suspect pregnancy. Those participants who did not plan the pregnancy, sought medical attention because they generally felt unwell , overtired, bloated and nauseous, as well as feeling unrecognized fetal movement. They also increased in body size despite food restriction and excessive exercise. Their diagnosis of pregnancy occured anywhere from late first trimester to late second trimester.

The late diagnosis of pregnancy for women suffering from eating disorders has been addressed in the literature. It is suggested by Bonne, Rubinoff, and Berry (1996) that the detection of pregnancy in

patients with eating disorders is likely to be delayed given that the subjective signs of pregnancy, namely breast tenderness, nausea, lightheadedness, and fatigue, are also feelings commonly reported by patients with eating disorders. Bonne, Rubinoff, and Berry (1996) also suggest that the prompt detection of pregnancy in women experiencing eating disorders is crucial given the increased rate of complications in this group (Weinfeld et al. 1977; Treasure & Russell, 1988; Fahy & O'Donoghue, 1991). It should also be noted that most authorities on eating disorders recommend that pregnancy take place only after the eating disorder has been resolved (Brinch, Isager, & Tostrup, 1988; Stewart, 1992; Franko & Walton, 1993).

One participant described an experience of being falsely pregnant but was psychologically convinced that she was pregnant. She had experienced signs of pregnancy such as fetal movement and increased body size. For this participant, "pregnancy" was an attempt at acceptance. This experience was unique to this participant.

**Initial Emotional Response**

For all women becoming pregnant brings on a flood of emotions. No matter what the situation may be--planned or unplanned--the knowledge of a body harboring a tiny life can be overwhelming. For a woman with an eating disorder, pregnancy brings on a whole new challenge as well. Everything she believes in in regards to food and exercise, must be abandoned for a greater assurance of safely carrying a healthy baby to term, thereby leaving a woman feeling in conflict with her own emotions.

Intense maternal emotions were described by all participants when they discovered they were pregnant. They experienced feelings such as being overwhelmed, out of control, shock, fear, and surprise. This reaction is, however, no different than the range of feelings identified amongst women in general when pregnancy is first diagnosed. Rubin (1970) reported that a woman experiences an element of surprise when discovering a pregnancy, even though the pregnancy may be desired or planned. These feelings of surprise produce mixed reactions of pleasure and displeasure which disappear at the time of quickening--although the participants do not refer to a time period in which their emotions subsided. Similarily, surprise and intensification of maternal emotion are described by other writers when discussing a woman's early pregnancy experience (Bergum, 1989; Campbell & Field, 1989; Trad, 1991; Valentine, 1982).

The feeling of being "out of control" does not appear to be an experience common to women who are pregnant in general. However, for the women in this study this was a very real emotion. Pregnancy also brought about emotions such as powerlessness and feelings of violation. These emotions are not associated with a diagnosis of pregnancy in the literature but appear to be common to the women in this study. This emotional response to the diagnosis of pregnancy was also not found in the research related to eating disorders during pregnancy.

After receiving the diagnosis of pregnancy, participants used action/interaction strategies to protect the health of the baby or protect their own self-image. The strategies of seeking reassurance, assessment of perceived risk to baby versus perceived threat to self, and the engagement in protective behaviours allowed participants to move towards one of the two competing motivators on a protecting continuum--either protecting their self-image (the pursuit of thinness), or protecting the baby (the pursuit of a healthy baby).

**Seeking Reassurance**

Reassurance from others was sought out by participants immediately following the diagnosis of pregnancy and continued throughout the pregnancy. Participants received reassurance from a variety of sources including health care professionals, family, and friends. The majority of participants did not disclose their eating disorders to others so they were careful about what information they provided while seeking reassurance.

The women in this study wanted reassurance that their baby was healthy. They attempted to receive this reassurance during their prenatal visits and also during casual conversations with family and friends whereby they would compare experiences. This action of conducting personal literature reviews related to childbirth by: seeking out other women who may provide experiential information; visiting the physician who assesses if the pregnancy is normal; and attending prenatal classes or self-help groups, assists the woman in making assurances about the safety and health of her baby (Campbell & Field, 1989).

Women in this study also experienced an intense desire to seek reassurance from family, friends, and health care providers about their physical presence, or rather their body size, shape, and weight. They also experienced the need for additional knowledge with respect to their situation. They sought out information from bookstores, libraries, physicians, dieticians, and eating disorder support groups. They

were disappointed with the lack of information and resources available to them. The lack of awareness also came as a surprise to participants since they anticipated that some helpful information would exist. The eating disorder support groups were few in number and participants who attended did not discuss eating disorders in pregnancy.

Reassurance was also given by the participants themselves. This experience existed primarily for multiparous women who were able to compare their current pregnancy with their previous one. If the previous pregnancy had a positive outcome which was the reality for the participants in this study, the participants reassured themselves that they could be less careful with their eating and exercise behaviours this pregnancy given that the last pregnancy had a positive outcome. This rationalization of behaviours existed throughout the pregnancy.

**Assessing Risk to Baby versus Threat to Self-Image**

The second action/interaction strategy of the social process of protecting is assessing risk to baby versus threat to self-image. The influence of factors such as fear, uncertainty, guilt, body image, motivation, support, and making the transition to parenthood all played a crucial part in a participants movement on the protecting continuum, moving either towards protecting baby or protecting self-image.

The feelings of protectiveness towards the fetus is experienced in varying degrees by all pregnant women (Ball, 1987; Bergum, 1989). In fact, Rubin (1975) describes the giving of oneself and protecting the well-being of the unborn child as essential tasks that a woman must achieve in the prenatal period in order to establish an identity as a mother. Failure to achieve these tasks of pregnancy can interfere with the woman's ability to establish a caretaking relationship with her baby and adapt to future parental roles (Cohen, 1979; Raphael-Leff, 1982; Rubin, 1975; Tanner, 1969).

All of the women in this study wished to have a healthy baby and believed that their eating disorder was not healthy for the baby. Eight of the women in this study, especially those who had disclosed their eating disorder to their health care provider, were knowledgeable about the potential risks to the baby and cited them as prematurity, low birth weight, malnourishment, and possible long term deficits (Treasure & Russell, 1988; Merlin, 1992). In addition to the above risks, obstetrical complications such as low apgar scores for newborns, intrauterine growth restriction, low maternal weight gain, hypertension, preeclapsia,

breech births, higher incidence of multiple pregnancies, fetal abnormalities of cleft lip and palate and medical intervention such as forceps, vacuum, or ceasarean section at the time of the birth have been associated with eating disorders (Fahy, 1991; Merlin, 1992).

The women in this study all report having a healthy baby. There was one report of multiple pregnancy which was undiagnosed until delivery. One participant had a history of spontaneous abortions. Maternal weight gain ranged from nine to forty eight pounds. Gestational age at time of delivery was preterm for four of the ten participants (deliveries prior to 37 weeks gestation) and two experienced preterm labour. Mild morning sickness was present for three of the participants during the first trimester. One participant was a smoker although the birthweights of her children did not reflect low birthweight infants (8 pounds, 6 ounces and 8 pounds 2 ounces). All the women had vaginal deliveries but three had assistance with a vacuum extraction and one with forceps. There was one report of a face presentation with subsequent prolonged labour and one participant fainted throughout labour. Most of the women described having "long" labours and reported fetal distress with the presence of meconium although it is difficult to associate this with the eating disorder. Birthweight ranged from five pounds, eight ounces to eight pounds eight ounces. The twins were born at 33 weeks and weighed slightly over three pounds each. The participants do not report any long term deficits in their children.

The participants who disclosed their eating disorder to their health care provider were labelled as "high-risk". They describe feeling fearful, anxious and uncertain as a result of being labelled. This is consistent with emotions described by other high risk pregnant women (Penticuff, 1982; Snyder, 1979). The emotions were believed to be validated due to the reported response of the health care provider of being more anxious and concerned about the participants pregnancies than they were themselves.

When exploring the potential risks to the baby during the interview, the participants often slipped into the second person when discussing this possibility. It appeared to be a way in which to further remove themselves from the reality of their situation. The "high-risk" label served as a reminder that there were additional risks associated with having an eating disorder during pregnancy. This brought the participants closer to the reality of their situation.

Once the participants had evaluated the risks to the baby, they weighed these risks against their own threat to their self-image as thin. It appeared as though the participants were attempting to balance the scales between two competing motivators: a healthy baby and the pursuit of thinness. Throughout their pregnancy the participants experienced intense emotions that were often in conflict. They describe being faced with the dilemma of losing their primary coping behaviour of disordered eating during a time of stress.

**Influencing Factors**

Seven factors were identified which influenced the process of protecting self-image and/or protecting baby. These factors include: (1) fear, (2) uncertainty, (3) guilt, (4) body image, (5) motivation, (6) support, and (7) making the transition to parenthood. Fear, uncertainty, guilt, and concern about body image were emotions which produced the motivation for the participants to alter their behaviours. The successful action was dependent on the degree of perceived support. The final influencing factor for participants was the transition to parenthood. The internal balancing of these factors along with the other stressors experienced during the pregnancy directed the participant to engage in protective behaviours.

All the women in this study experienced stressors during their pregnancy which, depending on how the stressor was interpreted and internalized, directed the women towards engaging in protective behaviours toward herself or her fetus. These stressors were events which occured during the pregnancy and were reflected in their stories.

## Fear

Participants identified their fears as: gaining weight, labelling, exposing the underlying issues, gender of the unborn child, surviving labour, and autonomy.

**Fear of gaining weight/Fear of fat**

There was a strong fear of gaining weight and being fat for all of the participants. This was not an unfamiliar emotion but it was directly challenged and intensified by their pregnancy. Despite their discomfort with weight gain, many gained an appropriate amount of weight during their pregnancy. While the gain was, in part, a result of the pregnancy itself, irrespective of the eating patterns, the majority of the participants did improve their eating and exercise patterns.

Despite the fact that pregnancy was seen as "permission" to be fat, the weight gain remained a source of anxiety for the women. One participant chose not to know how much weight she had gained at each of her prenatal appointments for fear of "triggering off" her eating disorder. Other participants described not wanting to know their weight gain because it was, in fact, a negative stressor for them that triggered negative and unhealthy eating behaviours. Weight gain seemed to serve as the indicator for body image in that the women could cope better if they were not forced to know their weight or weight gain throughout the pregnancy.

The fear of gaining weight is central to the experience of having an eating disorder. Given the inconsistency between being pregnant with an expected weight gain and having an eating disorder whereby one intensely fears gaining weight, one might propose that this may lead to conflicting emotions and actions. Exploration of these conflicting emotions and actions may provide a deeper understanding of the experience for women so that appropriate care can be provided.

**Fear of labelling**

Women in this study were afraid of being labelled if they disclosed their eating disorder during their pregnancy. The women who had previously disclosed their eating disorder experienced judgement-based care as a result of having disclosed. It was believed that a label was placed on them and resulted in them being treated "differently". As a result of this, few women disclosed their eating disorder to their caregiver during their pregnancy and for those that did, the experience varied. Some participants found that healthcare providers, although lacking in knowledge about this phenomena, were sensitive in their approach. Others found that health care providers were judgemental and insensitive, thereby reinforcing to the participants that they were "bad" and "unworthy" of having a child.

The experience of being different, bad, or unworthy was something which all of the participants could relate to since they had spent a lifetime feeling that in order to be accepted, they needed to be someone other than who they were. Pregnancy was seen as an opportunity for many of these participants to re-focus and engage in healthy behaviours for the health of the baby and indirectly for their own health. Participants feared disclosure and labelling since they would have to be accountable to others for their behaviours. Women suffering from eating disorders revel in the secrecy of their eating disorder. They

would also risk having demands and judgements placed on them. Labelling signified being different which was threatening in that these women have attempted throughout their life to be accepted.

**Fear of exposing the underlying issues**

The women in this study used their bodies as a means of speaking about pain, the pain of issues that were deeply rooted within their psyche. Pregnancy was an opportune time for the participants to begin the healing process since many of them were motivated to be healthy. This meant utilizing positive coping behaviours rather than their eating disorder to deal with their emotional pain. The result of removing the eating disorder as a coping mechanism was having the women feeling vulnerable, exposed, and fearful. The underlying issues tended to surface at this time leaving the participants in a dilemma of either facing these issues or supressing them through the use of their eating disorder or other coping mechanisms.

The underlying issues for the participants included sexual or physical abuse as children, abandonment, and being unaccepted by family and friends. They also reflected on their strained mother-daughter relationships. This was especially difficult since during pregnancy women often reflect on their own relationships with their mothers. This is consistent with research that suggests that pregnant women begin to reflect upon their relationships with their own mothers which assists them in preparing to mother their own infants (Campbell & Field, 1989; Coleman & Coleman, 1971; Raphael-Leff, 1991; Stainton, 1985). Since the participants relationships with their mothers were often in conflict and they were wanting to be unlike their mothers, the women found thinking about their mothers stressful. This also reinforced their fears of becoming parents since they did not wish to model their own upbringing.

**Fear of gender of the unborn child**

Three of the women spontaneously expressed concerns about the gender of their unborn child. All of these women had been abused sexually or physically. Their fears were in having a female child. The fear was that the baby girl was more susceptible to sexual or physical abuse. It is not uncommon for women who are expecting a child to desire a baby of a particular gender. One participant delivered a baby girl which was not what she desired although now that her daughter is three, she feels as though she was a blessing since she is having to address some of the issues of being a woman as a result of having a daughter. Having her daughter is part of the healing process for her. Rubin (1977) notes that disappointments related to a desired

gender take time to overcome and may delay or limit the attachment process. For this participant, having a baby girl helped her to embrace the child within and although this meant dealing with painful issues, she did not feel that is caused her to reject her daughter in any way.

The participants desired a healthy baby regardless of sex. This desire reflects the findings from Lever-Hense's (1989) study of livebirth following stillbirth. Participants in this study were faced with the challenge of carrying a child after having lost a child. Some of the participants in this study expressed desiring to have a healthy child regardless of gender. There was no literature found on fear of gender of the child in the research on eating disorder during pregnancy.

**Fear of surviving labour**

Many women fear the labour experience, in particular the pain associated with giving birth. The participants did not describe fearing labour pains, but rather they feared surviving the labour. There are many repercussions of eating disorders which involve the dermatologic, gastrointestinal, cardiovascular, renal and electrolyte, endocrine, musculoskelatal, metabolic, hematologic, and central nervous systems (Kaplan, 1990). When the delicate interplay of these systems is interrupted for prolonged periods of time, the human body responds by weakening. Since the demands of labour require a strong healthy body, a woman with an eating disorder may be fearful of her ability to cope during this stressful time.

Prior to labour, the women in this study experienced symptoms such as shortness of breath with subsequent fainting episodes, heart palpatations, blurred vision, racing pulses, and loss of consciousness, which for some became intensified in labour. Four participants experienced a prolonged labour which required assistance by forceps or vacuum extraction at delivery. This may be associated with reduced maternal energy and strength for those who were unable to eat appropriately during their pregnancy.

**Fear of autonomy**

Autonomy is a theme which is common to eating disorders although it has not been associated with eating disorders during pregnancy. Autonomy is conceptualized in the literature as self-assertion, making one's own choices and deciding one's expectations for oneself (White, 1992). The women feared being in charge of their pregnancies and of having to make decisions that would not only affect them but also their unborn children. This caused them to reflect on their own relationship with their families-of-origin. The

participants shared feelings of failure to develop autonomy early in life predominately due to over-control and intrusiveness by their mothers. As previously addressed, the strained mother-daughter relationship was seen as stressful. As a result of this lack of autonomy early in life, the participants felt vulnerable and unable to cope with the multiple demands and implications of being pregnant and having a child. However, during pregnancy the participants' had to become increasingly more autonomous as their unborn child became increasingly more dependent upon them--a reality which instilled fear in them. Despite their fears, the participants strongly believed that they would need to be more autonomous in order to be a good parent.

**Uncertainty**

The theme of uncertainty had different meanings for each of the participants in this study. Whatever the focus of the concern, all the women desired a successful pregnancy and a healthy baby. They knew that their behaviour pattern made achievement of these outcomes uncertain which led them to both assess the risks of their behaviours to themselves and the baby. They also balanced the scales between their needs and those of the baby which led them toward a choice of protective behaviours. The degree of knowledge that each woman had with respect to their risks varied but all expressed the uncertainty of maintaining the pregnancy until term.

McGeary (1991) describes the response to uncertainty based on a high risk status as that of "guarding". She describes guarding as a basic social psychological process whereby women actively respond to the uncertainty that they perceive. Similar to the experience of the women in this study, the participants in McGeary's study respond to uncertainty by guarding the baby while simultaneously guarding themselves. Guarding involved either raising one's guard or lowering one's guard depending on whether the uncertainty was perceived as threatening. If the uncertainty was threatening, as in perceived harm to baby, the participant's guard was raised. She would then respond by "doing things right" and/or by "seeking reassurance". If the uncertainty is reframed positively, there is a hope that the pregnancy progresses normally and that the outcome is a healthy baby. In this instance, the participant would lower her guard.

In this research study, participants responded to uncertainty within the context of having an eating disorder during the pregnancy. All of the women went through a process of protecting their self-image as thin and their unborn children although the two motivators were in competition and were at opposite ends of

a protecting continuum. Women responded to uncertainty by seeking reassurance as was seen in McGeary's study, but they also responded by assessing and balancing the competing risks and then engaging in protective behaviours. It appears that for the women in this study, their guard was never lowered since if one was to simply choose one motivator or the other (the pursuit of thinness or having a healthy baby), the other would be placed at risk and would therefore be in conflict with the participant's psyche. A common desire for all of the participants was a healthy baby, but the actions they took were not always consistent with an outcome such as this.

**Uncertain outcome**

Although there is no guarantee for the health of any baby, the participants were well aware that they could be at additional risk as a result of having an eating disorder both prior to and during their pregnancy. Mishel (1988a, 1988b, 1990) has been influential in the development of the concept of uncertainty in relation to illness. Although her conceptualization is that of uncertainty in illness rather than pregnancy, she suggests that when stimuli are perceived as uncertain, individuals experiencing an illness, or in this case a high risk pregnancy, may have difficulty developing a clear picture of the situation, due to the hinderence of the perceptual tasks of recognition and classification. Snyder (1979) supports this view when postulating that women experiencing a high risk pregnancy may lack an internal trajectory of childbearing from which to form perceptions and take actions.

The women in this study did not have a healthy internal frame of reference on which to accurately predict outcomes. They all also had a long history of expectations that were not met which left them somewhat unwilling to commit themselves to positive outcomes. They feared that their eating disorders might have adversely affected either their baby's mental or physical development. When discussing this uncertainty, women referred to their babies as "it".

## Guilt

For the majority of their lives, the women in this study felt guilty and responsible for events and actions over which they had no control. The eating disorder experienced by the participants was developed in part as a response to traumatic events that had taken place in their lives. Although the participants could recognize that their self-blame was irrational, their guilt feelings persisted. Once the women were pregnant,

they then began to experience guilt over their perceived responsibility--the health of their unborn child. Guilt is a deep-rooted emotion and participants found that it ran deep into their subconscious--so much so that one of the participants dreamed about her guilt. She feared that something was wrong with her baby and that it would be her fault and she would have to live with that for the rest of her life (Donna, 4.1).

Guilt is not a new emotion for women having histories of uncertain motherhood. The studies by Brady-Fryer, Diachuk, McGeary and Lever-Hense in Field and Marck's Uncertain motherhood: Negotiating the risks of the childbearing years (1994) all reflect maternal emotions of guilt despite the women recognizing that they were not to blame for their previous loss or their baby's present condition.

Participants were apprehensive about expressing their guilt feelings for fear that their "worst nightmares" would come true. Discussing their feelings of guilt with others also meant disclosing that they had an eating disorder which created an additional threat. Participants felt guilty about eating in general: about what they ate, how much they ate, how little they ate, when they ate and if any of their eating behaviours would adversely affect the baby. They describe having guilt as a constant in their lives. They felt guilty that they might be placing the baby at risk by restricting their intake and conversely they felt guilty when they did eat.

Women experience guilt as a result of having lost control of their eating as evidenced by engaging in binge eating behaviour and then having to purge to free themselves of the guilt (Abraham and Beumont, 1982). The guilt of overeating is then replaced by the guilt of purging. It appears to be cyclical in nature and dangerous in terms of its physical and emotional implications for women. This process has the potential to be intensified in pregnancy when the woman must add the unborn baby to this complex equation.

**Body Image**

Body image is a theme that is prevalent in the literature on eating disorders. Body image is complex, dynamic, and includes several elements including both physical and emotional states. Evidence suggests that women with eating disorders experience body image disturbances and that they have histories of personal experiences with social rejection in connection with their appearance (Zerbe, 1993). There appears to be an investment of self-worth centered around appearance or body weight, shape, and size in a woman with an eating disorder. If a woman's perceives that her appearance is unacceptable, she also sees

herself as having low self worth. The participants experienced body dissatisfaction as well as low self-worth. They believed that they were fat even during their pregnancy. Despite being underweight, most participants showed little concern for this pre-pregnant condition and continued to engage in unhealthy eating and exercise behaviours. A gap between the reality of their appearance and the participants perception of it was evident. Zerbe (1993) suggests that a dissatisfaction with body image in women with eating disorders is best viewed as a multidimensional phenomenon that involves perceptual, attitudinal, and behavioural features.

Body image was intensely affected by the pregnant shape that the women's bodies were adopting. This new body shape, weight, and size was in conflict with their goal or image of the "ideal" female physique. The women expressed varying degrees of body dissatisfaction which they closely related to the gestation period that they were in. The second trimester appeared to be the most difficult since it was "in-between" being "thin" and being "really pregnant". There were concerns expressed that the public perception during this phase may be that they were "just fat" as opposed to being pregnant. For women with eating disorders, self-worth is connected to appearance and how not only themselves but others perceive them. If a woman with an eating disorder was perceived as fat it would be harmful for that woman's psyche and could trigger even more dangerous eating behaviours. The second most difficult stage was the third trimester with obvious body size, shape, and weight changes taking place. Descriptions used included words such as "beached whales" and the women felt extremely uncomfortable with their size.

The first trimester was a difficult stage but this seemed to be more of a psychological response to upcoming changes in the pregnancy than a reaction to body changes. Some participants were also not aware that they were pregnant at this time and so did not view their bodies as pregnant. The researcher was unable to locate any research that identified particular trimesters of pregnancy as being more difficult to accept with respect to body image although this would be a valuable piece of information on which to base further studies--for both women who are pregnant and for those that have an eating disorder during their pregnancy. It has been reported in a study by Slade (1977) that during the early stages of pregnancy, most women overestimate face, chest, waist, and hip size, but by eight months of gestation, the difference between the real and perceived size decreases. This may be a positive adaptation to change and appears consistent with the findings of this study.

Many of the participants expressed concern about what their bodies would be like in the postpartum period. All felt strongly that they would have to lose their weight quickly following the delivery of the baby. Many admitted they were planning on returning to the unhealthy eating behaviours that they used prior to pregnancy. The women who had experienced previous pregnancies and lost weight quickly following the delivery using methods of restriction and excessive exercise planned to do this again once the baby was no longer dependent on them for nutrition.

Body image was also related to how their clothes fitted throughout the pregnancy and following delivery. Six participants refused to wear maternity clothes seeing them as "fat lady" clothing. Instead, most of the participants were able to wear their "casual" clothing that allowed for stretching. Following the delivery of the baby, all participants desired to immediately fit into their pre-pregnant clothing. This was not a realistic goal but participants actively engaged in behaviours such as food restriction and excessive exercise so they could achieve it. This response is consistent with research by Lacey and Smith (1987) and Willis and Rand (1988) who found that those women who experienced distress over their body shapes in the postpartum period unrealistically expected to be thin immediately following delivery.

**Motivation**

Participants were motivated to both have a healthy baby and to pursue thinness. These two motivators were incompatible and therefore were seen as competing by the participants. If they felt the pregnancy was not at great risk, they continued with their current behaviours, which often involved weight loss methods such as restriction, purging, excessive exercise, laxatives and stimulants. Those participants who had experienced a previous pregnancy tended to take additional risks with their behaviours given that the outcome of their previous pregnancy was a healthy baby. These women were influenced by their past experience, knowledge level, and their environment. This is consistent with Snyder's (1979) proposition that each woman has a trajectory of childbearing, a perceived model of pregnancy from which she views her own experience. The women in this study therefore reacted to their own pregnancy using their personal trajectory as a basis of comparison.

Women who felt the baby was not at great risk also felt a strong sense of threat to self image which may have contributed to their belief that the unborn child was not at risk as a result of their eating disorder.

These participants were more threatened by their changes in body shape, weight, and size than those women who felt their baby was at risk as a result of their eating disorder. They felt unable to cope with a growing body despite being cognitively aware that it was the growing baby. They tended to engage in more weight control methods and subsequently they demonstrated a lower maternal weight gain than other participants.

The participants who perceived that they were placing their baby at risk, modified their behaviour in order to have a healthy baby. This modification of behaviour, a process of *doing things right* (McGeary, 1991) has been noted previously (Corbin, 1987; Lever Hense, 1989; Penticuff, 1982). This willingness to modify maternal behaviours is closely aligned to two of Rubin's (1975) maternal tasks of pregnancy, *giving of oneself* and *ensuring safe passage*.

Participants in this study modified their maternal behaviours throughout the childbearing cycle, including pre-pregnancy for those women who were planning on having a child and knew that to become pregnant, they needed to eat healthily, stop using laxatives and stimulants, and moderate their exercise. The majority of participants were intensely motivated to have a healthy baby. Many of these participants describe pregnancy as their "permission" to be fat. It appears that for those participants who were committed to having a healthy child, they had to virtually let go of their controlled eating patterns since they could not find a balance between pursuing thinness and having a healthy baby. These participants tended to have increased maternal weight gain relative to the other women.

The postpartum period was difficult for all of the women. Although they were still motivated to have a healthy newborn, they were aware that the baby was not as dependent upon them for its' nutrition and therefore felt increasingly motivated to actively pursue thinness, even if the behaviours were considered dangerous. The birth of the child also motivated one participant to address sexual abuse. Despite their own needs, the participants were motivated to protect their infants and children.

Most of the women tended to engage in behaviours that were consistent with having a healthy baby. If they experienced a stressful event with which they could not cope, they would move back to unhealthy eating behaviours. For the most part, participants engaged in healthier eating behaviours during pregnancy than they did in a non-pregnancy state. One participant consistently struggled with remaining thin during her pregnancy and despite her wanting to have a healthy baby, she was unable to cope with her life

experience without utilizing her eating disorder during her pregnancy. She was recently separated from her husband although she describes this event as being a positive one in her life.

**Support**

*If one scheme of happiness fails,*
*human nature turns to another;*
*if the first calculation is wrong,*
*we make a second better;*
*we find comfort somewhere.*
*Jane Austen*

Women suffering from eating disorders have long been recognized as having disturbances in social relationships and family interactions (Tiller et al., 1997). The sharing of relationships and friendships with others is difficult for women with eating disorders and therefore their social network is often minimal (Dare & Crowther, 1995). This was evident in this study for while the women had relatively few means of social support, the support systems that participants did have in place proved influencial in helping participants cope with the challenges of having an eating disorder during their pregnancy. It should be noted that it is not the size of the social network that it important, but rather the quality of the relationships that make up that network (Mishel, 1990).

Participants report receiving support from family, friends, health care providers, and eating disorder support groups. The support that they received was positive. Some concerns were expressed by participants who received health care from male providers. Most participants felt more comfortable with female health care providers reporting that "females have probably dealt more with eating issues because more females face that struggle every day" (Bonnie, 2.1). It was also generally believed that females would be more understanding of the experience of pregnancy than would males. For those participants who continued to see male obstetricians, they found they were eventually able to establish a relationship of trust. They were referred to these male obstetricians since they were known to have eating disorders which therefore placed them in a high risk category. The obstetricians responded by being understanding, patient, and honest. This assisted the participants in feeling more comfortable with their health care providers.

Support groups for persons with eating disorders were also seen as a source of support where they were accessed. There was one eating disorder support group in Edmonton that was identified by participants but it's existence was known only to those hospitalized for their eating disorder. Another identified support group was Overeaters Anonymous but that group was not specific to women with anorexia nervosa or bulimia nervosa. All participants commented on the lack of support groups available and felt that it would be helpful if there were more in existence.

## Engaging in Protective Behaviours

Participants in this study wished to have a healthy baby although their behaviours were not always indicative of this desire. When the women perceived a risk to the baby, they engaged in behaviours that would ensure safe passage for their baby (Rubin, 1975). These protective behaviours were consistent with the "doing things right" behaviours that were engaged in by the five high-risk women who were guarding their uncertain pregnancy outcome in McGeary's (1991) study. These behaviours are also consistent with protective governing as proposed by Corbin (1987) and further explicated by Harris (1991). For the women in this study, doing things right and protective governing meant positively negotiating their eating and nutritional status during pregnancy.

### Healthy Coping Strategies

Seven of the participants engaged in healthy coping strategies during most of their pregnancy, that is behaviours that encouraged optimal nutrition in pregnancy. This optimal state was reached via the incorporation of three interactional events: the identification of underlying issues, nutritional education and guidance; and behaviour management.

Women who wished to engage in healthy behaviours needed to first identify the underlying issues that were contributing to their eating disorder. The underlying issues seemed to surface during pregnancy and were different for each participant. The issues addressed key themes such as body image, self-esteem, perfectionist beliefs, conflict resolution, stressors, and all of the influencing factors. The identification of underlying issues required the participants to get in touch with their inner child so that they could begin the process of healing.

Participants received nutritional education and guidance ideally from a dietician or nutritionist. Six of the ten participants had at some point received guidance from a nutritional specialist. The final step for healthy behaviours were to set realistic goals, establish a balanced exercise plan, manage food according to hunger level, or if this was not possible, engage in "mechanical" eating or "planned binges".

Setting a realistic goal meant planning on eating each and every day, one meal at a time, one snack at a time. Goals were no longer measured in terms of pounds or weight, but rather healthy behaviours. Participants utilized the Canada Food Guide as their resource to healthy eating. Most of the participants were unable to manage their behaviour by eating when they were hungry. As a result they engaged in what they describe as "mechanical eating" whereby they planned each and every meal according to what they would eat, when they would eat, where they would eat, how long they would allow themselves to eat, and whom they would eat with. By following this detailed plan, they were able to guarantee optimal nutritional intake. One participant was unable to completely eliminate her binging and purging so she engaged in "planned binges".

The use of planned binges is a behavioural technique aimed at the gradual reduction of binge-purge cycles (Steel, Farag, & Blaszczynski, 1995). It has been given tentative support by therapists as adjunct to other strategies used in the treatment of binging and purging behaviour. Although this behaviour does not eliminate the binging and purging behaviour, it does reduce the number of binges that occur. This behaviour was successful for the participant in this study who reduced her binging and purging episodes and also allowed her to remain in "control" of her behaviours. This behavioural strategy parallels other harm reduction models such as those used in the treatment of alcohol or drug dependence (Harm Reduction Working Group, 1993).

**Unhealthy Coping Strategies**

Unhealthy coping strategies are those behaviours that discourage optimal nutritional status during pregnancy. These unhealthy coping strategies are those which direct women towards protecting their self-image, or the pursuit of thinness. For the participants in this study, three in particular, the pattern of unhealthy coping strategies consisted of the overconcern with managing weight using weight control methods which subsequently lead to a state of hunger or starvation. The participant then chose to eat

healthily, overeat and possibly purge, or continue to restrict her intake. If restriction of intake had continued, participants would have been hospitalized. This continual restriction was usually accompanied by excessive exercise. Three of the participants were threatened with hospitalization if they did not alter their behaviours (all were severly restricting intake). They chose to go on a healthy eating plan to avoid hospitalization. For these participants, the threat of hospitalization proved to be an effective strategy for positive changes in behaviour.

### Making the Transition to Parenthood

Although the focus of this research study was to explore and describe participants' experiences with eating disorders during their pregnancy, it became clear during the interviews that the transition to parenthood was a major factor for the women in this study. The transition to parenthood began at the hospital following the delivery and continued through to the home environment. Many of the participants feel as though they are still making the transition.

Learning theorists propose that times of transition and major change can be optimal times for learning. Caplan (1961) views pregnancy as a time of psychological change and thus a time to promote learning and competency of an individual. Participants in this study were facing the simultaneous crisis of pregnancy and having an eating disorder. Most of the participants embraced the opportunity to learn about breastfeeding and baby care while at the hospital. After they went home, participants sought further information from their support systems on how to be an effective parent and a positive role model for their children. The participants wished to be good role models but they felt that they did not have any role models of their own on which to model their own parenting. Those who had older children reported that parenting became more difficult as the children grew older and gained independence. There was also additional fear that their children might model their own unhealthy eating and exercise behaviours. This would mean the children would learn to be preoccupied with their own body image. The majority of participants were concerned about the eating habits of their children. Some were concerned about their children's shape, size, and weight, and their own ability to model healthy eating patterns for their children. One participant felt that the challenge of parenting was so great that she chose to not have any more children, but rather to focus in on being as positive a role model as she can for the one child she has.

## Comments

In summary, the eating patterns of nine of the ten women in this study were improved once the participants knew they were pregnant, and for those participants who planned their pregnancy, their behaviours improved slightly prior to pregnancy. The eating disorder behaviour improved as gestation increased. Following delivery, all of the participants returned to some form of eating disordered behaviour. The participants who experienced more difficulty with managing their behaviours during pregnancy demonstrated a worsening of their eating disorder behaviours postpartum. Four of the ten participants improved their eating disorder behaviours when compared to their non-pregnant pattern. None of the participants felt they were cured of their eating disorder. Eight of the ten participants breastfed their infants. Two wanted to breastfeed but were told they did not have enough milk.

The results of this study are strongly suggestive that there was a positive attempt on the part of the participants to control their eating disorder because they were both motivated to have a healthy baby and fearful that if their eating disorder continued, they would harm the baby. The outcome of the protective behaviours for all participants, despite periodic unhealthy behaviours for some and extended unhealthy behaviours for others, was a healthy child.

This study is consistent with the findings from other research that report a temporary change in eating habits of women with eating disorders during their pregnancy. Earlier findings showed that women acquire the recommended weight gain and demonstrate renewed commitment to eating healthily in order to enhance their baby's health (Feingold, Lyons, Chaudbury, Costigan, & Cetrulo, 1988; Lacey & Smith, 1987; Mitchell, Seim, Glotter, Soll, & Pyle, 1991; Stewart, Rasking, Garfinkel, McDonald, & Robinson, 1987; Treasure & Russell, 1988; Willis & Rand, 1988).

In this research study the experience of the postpartum period and the adaptation to parenthood for the participants was not a focus. The findings reported are serendipitous to the study as a whole. Parenting behaviours of women with eating disorders and the eating habits of children of mothers with eating disorders have both been identified as areas of concern by the participants in this study. The children in these families may be more at risk for eating disorders.

**Propositional Statements**

Propositional statements derived from the findings of this study are:

1. Eating disorders are developed as a strategy for coping with some deeper, larger issue--food is a symbol of that deeper issue.
2. The preoccupation with eating, weight, body shape and size starts most often in childhood and is reinforced by cultural norms and values.
3. There are both predisposing and precipitating factors leading to the development of an eating disorder, with abuse appearing as a common factor.
4. The repetitive eating and eating disorder cycles are representative of internal models built by sufferers which temporarily numb emotional needs and satisfaction.
5. Hunger can be a destructive, frightening, disorganized experience which leads to lack of trust of self and others.
6. There is a split between mind and body. The eating and hunger temporarily replaces emotions such as guilt, fear, uncertainty, and other underlying issues and influencing factors.
7. There is a lack of awareness, understanding, information, and support available to women experiencing an eating disorder during their pregnancy.
8. Women experiencing an eating disorder during their pregnancy assess the health risks to their baby versus the threat to their own self-image as a thin person on an ongoing basis. They also seek reassurance about their image and the healthy behaviours they demonstrate from self and others on an ongoing basis.
9. Women experiencing eating disorders during their pregnancy engage in protective behaviours. These behaviours can be positive or negative and are motivated by perceived risks to their unborn child and perceived risks or threats to their self-image.
10. Women experience stressors that can be interpreted and internalized positively or negatively. The interpretation of the lived experience or stressor may vary between individuals. The response to the stressor is dependent upon the interpretation of the stressor.

11. Women negotiate eating and nutrition by engaging in either healthy or unhealthy coping behaviours. These behaviours are dependent on a woman's assessment of risk to her baby versus the threat to her self-image, influencing factors, reassurance given, and stressors experienced.

12. Recovery is a process and a journey. Women want to take that journey especially during a motivating time such as pregnancy but must feel safe and supported.

**Strengths and Limitations**

Participants were selected for this study using the purposive sampling method, therefore women were selected based upon their ability to provide information necessary to explore and describe the experience of having an eating disorder during pregnancy. This sampling method strengthened the study, as participants were selected who could provide detailed data relevant to the research questions. The researcher must acknowledge, however, that the participants in this study have reached a certain degree of "healing" and "self-discovery" in order to be able to acknowledge and discuss with the researcher their eating disorder during their pregnancy. A study exploring the experience for women denying their confirmed eating disorder while pregnant would provide comparison data as to how self-discovery and various stages of healing influence the experience but interviews with these women might be difficult to obtain.

The participants in this study were diverse in terms of age, education, and parity providing variation in their contributions to data collected. However, they represented a lower middle to upper class population and were homogeneous in terms of ethnic background; all participants were Caucasian. This small homogeneous sample does not allow for generalizations to other populations, except to other samples with the same demographic make-up. There is wide variation in experience within the sample which may imply that it is the interaction of a host of variables which influence the actual experience. It may be useful to replicate this study using inclusion criteria which limits the sample to one diagnosis--either anorexia nervosa or bulimia nervosa--rather than having a mixed sample as it would appear that there may be differences between the two groups in the way they negotiate their protective behaviours.

The researcher's knowledge and experience with pregnancy has also enhanced the reliability of the study since the researcher has a strong clinical and theoretical background in normal pregnancy. The researcher's own experience with living on the continuum of weight preoccupation has also provided

theoretical sensitivity when interviewing, coding, and analyzing data. Meeting with participants to discuss questions or concerns prior to the interview also enhanced comfort level and facilitated the interview process.

Participants were interviewed either during their pregnancy or shortly following a recent childbirth experience. This strengthened the study in that the scheduling allowed participants to comment on their current experience or reflect upon a recent experience. An additional strength of the study was allowing the participants to choose the place of interview. This provided the participant with some control over the situation and enhanced comfort level.

Another strength of the study is that the researcher transcribed two of the beginning interviews. This enabled her to critique her interviewing skills and become further immersed in the data. Subsequent interviews were transcribed by another party. All interviews were reviewed extensively by the researcher. Coding was done between interviews so emerging themes could be explored in subsequent interviews.

To further strengthen the design of this study, multiple interviews could be conducted from the time of diagnosis of pregnancy until the early postpartum experience. In this way, the early pregnancy could be captured as it unfolds, not retrospectively. However, this may be difficult in that many of these women are unaware of their pregnancy status due to their eating disorder until much further along in their pregnancy.

### Implications for Health Care Professionals

The eating disorders of anorexia nervosa and bulimia nervosa are important health problems for women today and therefore are a concern for the health professionals who work with women, and for the women themselves. The health care professionals who work with these women include midwives, nurses, physicians, and other supporting professions such as dieticians and psychologists. The primary focus of this section however will be to address the implications for both midwives and nurses. With the increased incidence of eating disorders, midwives and nurses are now more likely to encounter women suffering from eating disorders in a variety of settings. In the community, the midwife or nurse may be in an ideal position to first recognize disordered eating patterns, and in some instances, in collaboration with other health care professionals, may be able to supply appropriate support and treatment. In the hospital setting, midwives and nurses may encounter women with eating disorders in outpatient and inpatient settings. Midwives and

nurses are often the people to have the greatest amount of contact with these women, and they will be in a position to ensure continuity of care. Clearly the issue of eating disorders, and specifically eating disorders during pregnancy, has relevance for midwifery and nursing.

The findings of this research study have implications for midwifery and nursing in the areas of education, clinical practice, and further research.

**Education**

The current implications for midwifery and nursing education are widespread. Given the rise in prevalence, it is inevitable that more women experiencing eating disorders will be presenting themselves to midwives and nurses in various settings. Midwives and nurses will be in a position to first detect and then refer women to appropriate centers and health care providers specializing in eating disorders. Midwifery and nursing must take on additional responsibility for the development of better detection and referral services for this dynamic population. Some midwives and nurses may also be actively involved in the treatment process. In order for effective and appropriate detection, referral, and treatment to take place, health care professionals must be educated about eating disorders themselves as well as have a solid understanding of the underlying issues surrounding the development of eating disorders.

Midwives and nurses must be aware of the impact that eating disorders have on women's health, and subsequently respond to women in a sensitive, understanding, nonjudgmental and appropriate manner. A relationship of trust is essential given that clients with eating disorders often have a narrow view of the health provider as someone whose chief aim is to make them gain weight--the very thing that they fear most. Midwives and nurses must therefore learn to develop a therapeutic alliance with their clients. The principles of therapeutic alliance include the: establishment of a supportive, non-judgemental approach; acknowledgment of the client's suffering and distress; recognition of the client's need for control; clear expression of the wish to be helpful; demonstration of interest in the client's life; frequent recognition of efforts and strengths; and wherever possible, work on client-articulated goals and expectations (Deering, 1987). These principles also apply to the families of those living with an eating disorder.

It is believed that the incorporation of a feminist philosophy into midwifery/nursing education and practice will challenge traditional attitudes and values which will have a beneficial effect on women's

self-concept and sense of self-ownership (Leuning, 1994; Sampselle, 1990). This, in turn, will likely have a positive impact on both the current and the future of women's health.

Midwives and nurses are in an influential position to also take steps to prevent eating disorders. This may be accomplished through consciousness-raising, media-influencing, and education. This may be initiated in basic midwifery and nursing education whereby new concepts on women's health and eating disorders can be incorporated into the curricula. Then, when students graduate, they may better incorporate the feminist philosophy into their practice. It is possible that women with eating disorders may best be served by professionals such as midwives who are educated in a system that has a strong feminist philosophy.

**Clinical Practice**

Because of the increased prevalence of eating disorders during pregnancy, health care providers practicing in hospital and community settings must become aware of the unique needs of these women. Provision of information to women who may have disclosed their eating disorder to their care provider while receiving prenatal care, such as nutritional requirements, available support groups, signs of a healthy pregnancy and baby, signs of complications, reassurance, and reinforcement for positive healthy behaviours would assist women in gaining knowledge and comfort concerning their experience.

It may be helpful for women to begin to feel comfortable disclosing their concerns about their eating disorders to their care providers. A certain beginning level of comfort may be formed during prenatal classes whereby the discussion of nutrition in pregnancy provides information with a non-judgemental approach. With increasing levels of comfort surrounding eating disorders amongst health care providers, including prenatal instructors, an environment which is sensitive and understanding of the needs and issues of the women affected can be created. This may, in turn, indirectly encourage more women to feel comfortable disclosing their eating disorder so that they may receive appropriate and sensitive health care.

Education may also follow through from prenatal classes to postnatal parent groups and postnatal exercise classes. These classes may offer support, encouragment, and information and may assist women in regulating their weight safely while using healthy coping strategies. The postpartum period is a vulnerable time for women with eating disorders, so any continuity of care and consistency of information given to

these women is essential. Information regarding nutrition for their children as well as themselves would also be of benefit.

Some midwives and nurses may also be responsible for performing physical examinations so will therefore need to be aware of physical signs of eating disorders and blood/electrolyte imbalances. The midwife/nurse should pay close attention to physical signs such as: excessive hair loss (protein-calorie malnutrition), dry skin (zinc deficiency), lanugo hair, parotid hypertrophy (vomiting or protein-calorie malnutrition), erosion of dentition and gingival disease, Russell's sign (scaring on the hand from induced vomiting), slow pulse rate and low blood pressure, mitral valve prolapse (low body weight), and cardiac dysrhythmias (fluid/electrolyte imbalance). A detailed history of eating habits should also be a part of the routine workup of the pregnant client.

There are specific strategies that midwives and nurses may use to effectively care for clients experiencing an eating disorder during their pregnancy. The principles of therapeutic alliance must be adhered to but in addition to this, health care providers are in a unique position to influence positive behaviours in their clients. When assessing the health of the pregnancy, it is not necessary to weigh the client at every prenatal visit. There are other measurements, such as fundal height and ultrasound, that may be used to assess for fetal growth. If each or alternate prenatal visits require a measurement of weight gain, the client should be provided the option of being made aware of her weight gain/loss status. The focus of prenatal visits should be on the client's strengths and positive behaviours rather than on her weight. A detailed nutritional intake history should be taken with reinforcement of the benefits of optimal nutrition for both mother and baby being provided. It may be necessary for the client to take vitamins and minerals in addition to the prenatal vitamins due to increased demand and latent deficiencies in the body unmasked by pregnancy. Symptoms of deficiencies such as muscle weakness (K, PO4 ) and muscle cramps (Mg) should be reassessed during the pregnancy. Referrals should also be made to a nutritionist or dietician who provide detailed nutritional guidance that can be supported by nurses. The midwife/nurse practitioner's role centres around support and education of the client. The midwife or nurse should encourage realistic expectations, reinforce any normalization of eating habits, and provide accurate guidance and reassurance about the client's concerns.

Health care professionals can also assess women's social support systems and provide information regarding community agencies that may assist these women. Support is pivotal so any information that is provided to them may have a significant impact on their protective behaviours. A midwife or nurse must also demonstrate sensitivity to the pregnant woman's feelings and fears which will assist her to cope with the changes in her expectations for her future. They may also have a role in the provision of immediate feedback to pregnant women regarding tests such as ultrasound which indicate fetal well-being but must be aware that not all women may find these examinations reassuring. It is also of importance to note that women may seek out preconceptual counselling which may involve midwives or nurses. This presents as an opportune time to screen women for eating disorders so that treatment may begin prior to pregnancy or as early as possible in the pregnancy. Eating disorder clients should be encouraged to achieve maximal recovery before conceiving.

The birthing experience may not be met with blissful anticipation but rather apprehension due to a woman's fear of her own ability to not only cope with, but physically survive labour. There may also be feelings of uncertainty regarding fetal outcome and her ability to become a mother. Any underlying issues may also surface at this time posing an even greater threat to the woman. An awareness of the possible existence of feelings such as these, acceptance of the individual woman's fears, and ability to reassure women that these feelings are normal are midwifery and nursing qualities that will assist the woman through her intrapartum experience.

The postpartum period must also be treated with special care. Women with eating disorders who have just delivered their babies may require more assistance in the early postpartum period to overcome their uncertainty and doubt regarding their ability to mother their infant. Providing reassurance, encouragement, and anticipatory guidance regarding feeding their baby, neonatal care, time management, and coping strategies for self and family will assist women with eating disorders who have recently delivered their babies to assume the responsibility of caring for their infant, and for themselves. Providing the family with resources and available support groups to access following the postpartum period would also be of importance and benefit since recovery is a time-consuming and exhaustive process.

**Midwifery/Nursing Research**

Using a qualitative exploratory-descriptive method to describe the experience for women of having an eating disorder during pregnancy has stimulated ideas for further research. Using a larger sample size and a more homogeneous group that have either anorexia nervosa or bulimia nervosa could generate important data on the differences between the two eating disorders and their implications during and post pregnancy. The qualitative method of grounded theory could also be used to further study the process of the transition to becoming a mother for women with anorexia nervosa or bulimia nervosa.

Focus groups could be used to further validate research findings. Nichols and Humenick (1988) state that focus groups work best if participants are similar, thus having one focus group comprised of women with anorexia nervosa who have been pregnant and a second focus group of women with bulimia nervosa who have been pregnant may help identify the differences in learning needs and approaches from a women's health perspective.

From the point of view of women in this study, there is a lack of information available to them on how to begin to deal with the dynamics of having an eating disorder while being pregnant. There is also a paucity of information available that specifically describes the incidence of anorexia and bulimia in pregnancy and the fertility rate of these women. Further research is necessary in order to establish a true estimate of the incidence of eating disorders in pregnancy and the impact on fertility. Studies about the experience of having an eating disorder while being pregnant were not found. An assessment of the needs of the women experiencing an eating disorder during their pregnancy would be of value in assisting midwives and nurses to identify areas of concern from the perspective of those experiencing the eating disorder and pregnancy. It may be of value to develop and evaluate the use of a scale for measuring a woman's perceived place on the continuum between protecting her self-image and protecting the health of her baby. This may serve to provide useful information to members of the health care team responsible for providing care to these women. In addition, the negotiation of nutrition and eating in pregnancy has not been addressed by the literature. It is therefore hoped that this research will be a foundation on which to base further research studies.

The postpartum period is a time of vulnerability for women with eating disorders. Research studies focusing on the differences between adaptation strategies during the postpartum period for women with anorexia nervosa or bulimia nervosa may provide information about factors associated with and influencing eating disorders. There is little research available on the children of mothers with anorexia nervosa or bulimia nervosa, further research is therefore needed.

Clearly there is still much to be learned about eating disorders in general, and specifically about eating disorders during pregnancy. It is hoped that through further research, a beginning understanding and awareness will exist amongst women and health care professionals alike so that women with eating disorders will feel increasingly more comfortable disclosing their eating disorders and thereby receiving the quality of care which they deserve. This becomes even that much more important during pregnancy as the life of the unborn child also benefits from its mother's care.

## Overcoming Barriers

There are many barriers towards achieving a state of health for women with eating disorders. These include: professional barriers (involving health care professionals who interact with these women on a frequent basis through many different avenues); personal barriers that affect the individual woman directly, and; system barriers that involve our current health care system. It is important to be able to identify these barriers so that we may be able to challenge them with the aim of "breaking down the walls", thereby moving towards a culture which embraces, values, and appreciates each others needs, beliefs, and differences.

### Professional Barriers

Midwives, nurses and other health care professionals have their own reasons for not feeling comfortable exploring eating disorders or other women's health issues. Some of these barriers may include:

1. ***Personal experience with eating disorders***

Many female health care professionals have had experiences with weight preoccupation and disordered eating, or may have experienced the impact of eating disorders in their families or other relationships. It is necessary to examine our own attitudes and beliefs to avoid ignoring, minimizing, or making harsh judgements about our clients and their eating disorders.

2. *Different views of eating disorders*

Health care professionals often have differing views of what constitutes an eating disorder. For some women, seemingly non-problematic behaviours or symptoms have a severe impact on their lives. Each woman must be evaluated as a unique individual having her own unique issues.

3. *Lack of education/experience in identifying and dealing with women with eating disorders*

Although the awareness of eating disorders is increasing largely due to organizations that specialize in the area, more education needs to be provided to health care professionals in general so that they may be more acutely aware of the symptomology of eating disorders. It is beneficial to identify individuals at risk and begin prevention education rather than treating an acute or chronic disorder. Health care providers can have great influence in the prevention of eating disorders.

4. *Attitudes toward women with eating disorders, especially those who are pregnant while suffering from the eating disorder*

Strong feelings toward women who suffer from eating disorders, especially when pregnant, can influence the individual's ability to address or deal with a client's issues. Women with eating disorders are very quick to recognize these attitudes. It is important not to blame a woman for what is happening. Eating disorders can be used as coping mechanisms for distress. Blame creates distance and reinforces a sense of failure.

**Client Barriers**

1. *Fear of the caregiver's disapproval*

Women are unlikely to disclose their eating disorder if they believe the caregiver will disapprove, judge, or not listen to what they have to say. This barrier not only blocks information exchange, but also reinforces the woman's belief in the need for secrecy and denial. It is important to support the woman, letting her know that you are aware of what's happening and that you care. Allowing the woman to vocalize her feelings by listening is crucial.

2. *Gender of caregiver*

For some women, the gender of the caregiver may hinder her ability to share experiences, largely resulting from a history of previous abuse. Ideally, the woman's preference should be discussed.

3. ***Blocked memories***

Women with eating disorders may block out memories of their experiences. Caregivers need to be aware that their clients may not remember all or some of specific incidences. Once again, supporting the woman is critical. Patience is important since recovery is a process and a journey.

4. ***Denial***

Denial and secrecy are common dynamics in a family with issues related to eating disorders. The caregiver must find supportive ways to get beyond this stage. A confrontational attitude will usually strengthen resistance.

5. ***Self-protection/fear of disclosure***

Women may fear the perceived consequences of disclosure of their eating disorder. Disclosure may also leave the woman feeling embarrassed or ashamed, or fearful of stigmatization because of negative attitudes. There may also be concerns about maintaining custody of their children. Confidentiality and respect for the women are essential. The development of a trusting relationship is key to a woman feeling comfortable with disclosing her eating disorder.

6. ***Fatalism***

Women may see no way out of their problems and accept the eating disorders as their lot in life.

7. ***Fear of being labelled***

Women may see that their "disordered eating" is causing problems in their lives but may reject the label of "eating disorder" as too harsh or extreme.

8. ***The stigma attached to seeking help***

For some women, there may exist a strong cultural bias that suggests people need to be strong and in control of their lives. Seeking help from a counsellor, midwife, nurse, or other health care professional may be perceived as a character defect that suggests weakness and contradicts the tenet that they should work through their own problems without relying on help from others.

**Health Care Delivery System Barriers**

The health care delivery system is currently in a state of transition and change. Women continue to play an important role in the system as health care consumers. Given that women will continue to access the

health care system, even if not by traditional means, the health care delivery system will be impacted by the number of women who experience eating disorders. Eating disorders are relevant to the health care delivery sytem.

The current implications of eating disorders and the health care delivery system are that the system is seemingly unaware of the magnitude of this women's health issue. The current changes in the delivery of health care have not reflected the need for further services which focus on women's health and women's issues, namely those of eating disorders. The future implications of this may include more women not receiving the appropriate referral and treatment that is critical to successfully break the eating and weight preoccupation. The women's epidemic of preoccupation with eating and weight will continue until it is given its due attention by the health care system. Some of the additional barriers include:

1. ***Limitations created by agency mandates***

Agencies usually have a clear mandate as to which problems they will handle and which must be referred elsewhere. Time, resources, and the agency's philosophy may all contribute to service delivery limitations.

2. ***Inadequate referral availability***

Agencies may not explore eating disorders because they are not aware of appropriate resources for women with this disorder, or these resources are not available in their community.

3. ***Lack of interagency cooperation and communication***

This lack of sharing information can impair treatment planning and service delivery. While interagency networking is often desirable, factors such as conflicting beliefs, limited staffing, and heavy caseloads can make implementation difficult.

4. ***Program inaccessibility***

Demand on the services of referral targets may result in long waitlists. Women may "fall through the cracks" waiting for admission to a particular agency or program. Some programs may be geographically, financially, or physically inaccessible. Agency hours of operation may be too restrictive.

## Summary

It is hoped that exploring and describing the experience of having an eating disorder during pregnancy will provide not only the women who have this experience, but also health care providers and the larger society, an enhanced awareness and understanding of this complex phenomena so that these special women can experience the specialized quality of care that they deserve. Further to this, it is hoped that this research study will provide the impetus for further research into the area of eating disorders during pregnancy and related women's health issues.

It is also hoped that through the achievement of a greater awareness and understanding of women's health issues, in particular eating disorders, a climate may be cultivated which accepts diversity in body size, shape, and eating behaviour, and a social context that encourages women to meet their nutritional requirements and their needs for emotional nurturance.

Those individuals with eating disorders retain tremendous strength, which may be hidden for a time, throughout their troubles. This strength resurfaces helping them recover and become stronger individuals. How to recognize and work with this strength is the challenge of all affected by eating disorders. There are many women today faced with finding effective and healthy ways to identify, and cope with, uncomfortable or painful issues in their lives. The following passage may serve as a great source of inner strength, courage, and conviction for all of us on while we navigate our journey through life:

**When human beings understand their place in the universe,
they will become able to grow to assume that place.
But the answer is not in the words of this page.
The answer lies within you.**

**You can become a channel and a great source of inner strength.
But you must give up everything in order to gain everything.**

**What must you give up?
All that is truly you;
all that you have chosen without choosing
and value without evaluating,
accepting because of someone else's extrinsic judgment,
rather than your own;
all your self doubt that keeps you from trusting
and loving yourself or other human beings.**

**What will you gain?
Only your true self;
a self who is at peace,
who is able to truly love and be loved,
and who understands who and what she is meant for.
But you can be yourself only if you are no one else.
You must give up 'their' approval, whoever 'they' are,
and look to yourself for evaluation of success and failure,
in terms of your own level of aspiration that is
consistent with your values.**

**Nothing is simpler
and nothing is more difficult.**

**Kubler-Ross, 1973**

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# APPENDIX A

## Eating Disorders Diagnostic Criteria*

**Anorexia Nervosa**

1. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85 % of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85 % of that expected).
2. Intense fear of gaining weight or becoming fat, even though underweight.
3. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.
4. In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhoea if her periods occur only following hormone, e.g., estrogen administration.)

**Specify type**:

**Restricting Type**: during the current episode of Anorexia Nervosa, the person has not regularly engaged in binge-eating or purging behaviour (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

**Binge-Eating/Purging Type**: during the current episode of Anorexia Nervosa, the person has regularly engaged in binge-eating or purging behaviour (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

**Bulimia Nervosa**

1. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

   (A) eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances

   (B) a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)

2. Recurrent 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.

3. The binge eating and inappropriate compensatory behaviours both occur, on average, at least twice a week for 3 months.

4. Self-evaluation is unduly influenced by body shape and weight.

5. The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

**Specify type:**

**Purging Type**: during the current episode of Bulimia Nervosa, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.

**Nonpurging Type**: during the current episode of Bulimia Nervosa, the person has used other inappropriate compensatory behaviours, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.

**Eating Disorder Not Otherwise Specified**

1. For females, all of the criteria for Anorexia nervosa are met except that the individual has regular menses.
2. All of the criteria for Anorexia Nervosa are met except that, despite significant weight loss, the individual's current weight is in the normal range.
3. All of the criteria for Bulimia Nervosa are met except that the binge eating and inappropriate compensatory mechanisms occur at a frequency of less than twice a week or for a duration of less than 3 months.
4. The regular use of inappropriate compensatory behaviour by an individual of normal body weight after eating small amounts of food (e.g., self-induced vomiting after the consumption of two cookies).
5. Repeatedly chewing and spitting out, but not swallowing, large amounts of food.
6. Binge-eating disorder: recurrent episodes of binge eating in the absence of the regular use of inappropriate compensatory behaviours characteristic of Bulimia Nervosa.

*American Psychiatric Association. (1994). Diagnostic and Statistical Manual of Mental Disorders, (4th. ed.). American Psychiatric Association, Washington, D.C.

# APPENDIX B

## Advertisement for participants

### Eating Disorders During Pregnancy

A nurse from the University of Alberta wishes to talk with women who have, or have had, anorexia or bulimia during their pregnancy. If this describes you, you can take part in this research project. Please call (403) 4-- ---- for more information.

## APPENDIX C

### Information Letter

**Project Title: Eating Disorders During Pregnancy**

**Researcher: Becky C. Hill, R.N.** **Phone: (403) 4-- ----**

My name is Becky Hill. I am a student in a master of nursing program. I am studying the experiences of women who have an eating disorder during their pregnancy. I am wanting to talk with women who have had this experience and would be willing to share what this was like for them. Your pregnancy must have been in the past five years.

If you agree to take part in this study, you will be interviewed one to three times for about 60 to 90 minutes each time. During this interview you will be asked some questions about your experience with eating during your pregnancy. You will also be asked some questions about yourself and your childbirth history. Each interview will be done in person or by telephone and will be tape recorded. The Child Welfare Act states that child abuse or neglect must be reported. Child abuse is the mistreatment or neglect of children. Child abuse may be physical, psychological, or sexual. It threatens the well-being or security of the child. If you tell me something about child abuse or neglect which is happening now, I will talk to you about it, but will also need to provide this information to Family and Social Services. All other information will remain confidential. When this study is finished, a report will be written. This report may contain some of your words, but your name will not be used. You will be given a make-believe name.

You may drop out of the study at any time, if you wish. You can refuse to answer any question. If you take part in the study, a summary of the findings will be made available to you at your request. The results of this study may help health care workers better understand what this experience is like so that they can provide better care. There are no direct benefits to you from taking part in this study, but it may help other women in the future.

If you want more information about, or wish to take part in the study, please call: Becky Hill at (403) 4-- ----. If there is no answer, please leave your name and telephone number on the answering machine. Thank you.

Sincerely,

Becky Hill, R.N.

## APPENDIX D

### Informed Consent Form

**Project Title: Eating Disorders During Pregnancy**

**Researcher:**
Becky C. Hill
MN/Nurse-Midwifery Candidate
Faculty of Nursing
University of Alberta
(403) 4-- ----

**Thesis Supervisor**
Dr. Peggy Anne Field
Professor of Nursing
Faculty of Nursing
University of Alberta
(403) 4-- ----

The purpose of this study is to explore and describe the experiences of women who have had an eating disorder during their pregnancy.

Your participation in this study will involve the following:
- The researcher will interview you one to three times.
- The interviews will be in person or by telephone and will take place at a time and place convenient to you.
- The interviews will last from 60 to 90 minutes each.
- All interviews will be tape-recorded by the researcher.

Besides the researcher, only the typist will listen to the tapes, but thesis committee members may read the typed copies. The tapes and typed copies will be kept in a locked drawer during the study. The consent form will be kept in a separate locked drawer. The tapes will be retained for a minimum of seven years after the study is completed and the research is published. The consent form will be retained for a minimum of five years after publication of the research. The typed copy may be used for another study in the future. If it is, the researcher will get approval from an ethics committee, as was done for this research. The findings of this study may be presented at conferences or may be published. Your comments from the interviews may be used but your name or any other information that may identify you will not be used. You will be given a make-believe name.

Your participation in this study is your choice:
- You may refuse to answer any question during an interview.
- You may stop the interview at any point.
- You may withdraw from the study at any time by telling the researcher.
- You may not benefit from being in this study. You will not be harmed if you take part in this study. Your participation may help other women in the future.

This is to certify that I _____(print name) agree to be in this research project. I am aware of the purpose of the study and what is involved. All questions have been answered to my satisfaction. I am aware that each interview will be tape-recorded by the researcher. The Child Welfare Act states that child abuse or neglect must be reported. Child abuse is the mistreatment or neglect of children. Child abuse may be physical, emotional, or sexual. It threatens the well-being or security of the child. If you tell the researcher something about child abuse or neglect which is happening, or that a child is at risk, she will talk to you about it. The researcher will also need to provide this information to Family and Social Services. All other information will remain confidential. I understand that I am free to withdraw from the study at any time. I have been given a copy of this form to keep. I can call the researcher or her supervisor at any time if I have questions or concerns.

Signature of Participant _____ Date _____

Signature of Researcher _____ Date _____

**********

If you wish to receive a summary of the study when it is finished, please complete the following:

Name: _____

Address: _____

## APPENDIX E

### Interview Guide

1. **Tell me about your eating disorder, start where you would like:**

*Probes:*

- How would you relate the disorder to your life in general?
- How has your eating disorder affected your life?
- When did it begin?
- How did it begin?
- What was going on in your life at the time you began to have an eating disorder?
- Is there anything which contributes to, or influences your eating disorder; positively? negatively?
- Is there anything else about your eating disorder you would like to tell me?

2. **Tell me about your pregnancy:**

*Probes:*

- What were some of the feelings you had when you knew that you were pregnant?
- Can you describe for me what your biggest concern about being pregnant is?
- Can you explore for me why this is a concern for you?
- How has the pregnancy affected your life?
- Is there anything else about your pregnancy you would like to tell me?

3. **Tell me what it was like for you to have an eating disorder during your pregnancy:**

*Probes:*

- How would you describe your eating patterns during your pregnancy?
- Did you notice any difference between your eating disorder before and during pregnancy?
- Are these patterns different from when you are not pregnant? If so, how? why?
- Did these patterns change during your pregnancy? If so, how? why?
- When you think of eating during your pregnancy, what thoughts and feelings come to mind?
- When you think of gaining weight during your pregnancy, what thoughts and feelings come to mind? What meaning does this have for you?
- Is there anything else about having an eating disorder during your pregnancy you would like to tell me?

4. **Can you tell me about any health risks to yourself or to your baby that may be related to your eating disorder during your pregnancy?**

*Probes:*

- How does this have relevance for you?
- What do you believe about the things that you have been told about eating disorders during pregnancy? Will these things have an effect on you or your baby?

5. **Can you tell me how you manage, or stay healthy with, your eating disorder?**

*Probes:*

- Do you feel that you are managing your eating disorder?
- What does managing your eating disorder mean for you?
- How do you manage?
- What methods would you typically use to manage your weight?
  (exercise, starvation, diet, purging, laxatives, appetite suppressants, others)
- Is managing your eating disorder important to you? Why?

6. **What information about your eating and nutritional status would you share with your health care provider during your pregnancy? For what reasons did you choose to either disclose or conceal this information?**

7. **As a person, how would you describe yourself?**

   *Probes*: - Friendly? Happy? Content? Secure? Anxious?

8. **Is there anything else that you wish to share with me regarding your eating disorder and/or your pregnancy?**

## APPENDIX F

### Background Data Form

Age:_____ (years)
Marital Status: (Married/Single/Divorced/Widowed) _____
Occupation: (either current or previous) _____
Education: (highest level completed) _____
**********

**PERSONAL AND CHILDBIRTH HISTORY**

Eating Disorder classified as: (Anorexia Nervosa/Bulimia Nervosa/ Unspecified)
(Appendix A):_____
Onset of Eating Disorder: (age of onset) _____(years)
Is there a family history of Eating Disorders? _____(Yes/No)
Is the Eating Disorder currently active, in remission, or resolved:_____
Characteristics of Eating Disorder as described by participant (methods of weight control used):
_____
_____
Has treatment ever been received for the Eating Disorder? _____(Yes/No)
What has this treatment involved?
_____
Height _____
Gravida_____Term _____ Preterm _____ Abortion _____Living_____
**********

**For each pregnancy, please record the:**

Maternal weight gain: _____
Pre-pregnancy weight: _____
Weeks at delivery: (gestational age) _____ (weeks)
Delivery Type: (Vaginal or C/S) _____
Any complications of the pregnancy or birth:
_____
_____
Did you experience morning sickness during your pregnancy?_____(Yes/No)
Did you smoke during your pregnancy? _____(Yes/No)
Sex of the child: _____(Male/Female)
Birth weight: _____(grams)
Did you breastfeed? _____(Yes/No)
Present health of the child:
_____

What weight control measures were used during pregnancy?
_____
_____
_____
(exercise, starvation, diet, purging, laxatives, appetite suppressants, others)

## APPENDIX G

### Characteristics of Participants

| Charact./Participants | A** | B | C | D** | E | F** | G | H | I | J | K* | L* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Age (years) | 29 | 30 | 30 | 31 | 31 | 38 | 28 | 36 | 26 | 35 | 41 | 44 |
| Marital Status:<br>M=Married S=Single<br>CL=CommonLaw<br>D=Divorced | M | CL | M | D | M | M | M | D | M | M | D | M |
| Occupation | Teacher | Home | Nurse | UIC | Sales | Writer | Nurse | Nurse | Clerk | Acct | Clerk | Secr. |
| Education:<br>HS=High School D=Degree<br>T=Tech. School G=Grad Std. | D | HS + | D | HS | HS | G | T | T | HS | HS | HS | HS |
| Eating Disorder (ED):<br>AN=Anorexia Nervosa<br>R=Restricting/BP=BingePurge<br>BN=Bulimia Nervosa<br>P=Purging/NP=Nonpurging | AN: R | AN: R | AN: BP | AN: R | BN: P | AN: BP | BN: P | AN: R | AN: BP | AN: R | AN: R | BN: P |
| Onset of ED (years) | 15 | 13 | 13 | 11 | 15 | 12 | 17 | 12 | 11 | 12 | 13 | 22 |
| Family Hx of ED: Yes/No | ? | ? sister | No | No | No | ? brothers | No | No | No | No | No | No |
| ED Status:<br>A=Active/R=Remission | A | R | A | A | R | R-preg. | A | A | A | A | R | R |
| Methods of wt. control:<br>R=Restricting E=Exercize<br>S=Stimulants D=Diuretics<br>P=Purging C=Cigarettes<br>L=Laxatives | R E | R E<br>C L | R E<br>C L P | R | L P<br>S D | R E<br>D | E P<br>L D | R E<br>L S | R E<br>P D | R L<br>C | R E | E P<br>L D |
| Tx for ED: Yes/No | Yes | Yes | Yes | Yes | No | Yes | Yes | Yes | Yes | No | Yes | Yes |
| Describe Tx:<br>H=Hospital M=Meds<br>SG=Support Group<br>P/MD=Psychiatrist<br>P=Psychologist<br>D=Dietician | H M D<br>SG P<br>P/MD | H M<br>SG | M SG<br>D P | H M<br>SG D P<br>P/MD | N/A | SG P<br>D | M D SG<br>P/MD P | M D<br>P | SG | N/A | P/MD | P |

*Secondary Participants

**Participants currently Pregnant

| Charact./Participants | A** | B | C | D** | E | F** | G | H | I | J | K* | L* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PREGNANCY: Gravida/Term/ Preterm/Abortion/Living | 21001 | 21011 | 11001 | 32002 | 20203 | 32002 | 11001 | 60151 | 10101 | 22002 | 21011 | 21102 |
| Maternal wt. gain (lbs) | 33 | 48 | 31 | 45 | 45 | ? | 36 | 44 | 20 | 9 | 16 | 25-30 |
| Pregnancy #2 | 28 | | | 34 | 28 | ? | | | | 16 | | 25 |
| Pregnancy #3 | | | | 15 | | ? | | | | | | |
| Prepregnancy wt. (lbs) | 99 | 92 | 102 | 110 | 124 | N/A | 114 | 104 | 110 | 128 | ? | ? |
| Pregnancy #2 | 107 | | | 120 | 130 | | | | | 126 | | |
| Pregnancy #3 | | | | 115 | | | | | | | | |
| Gest.age at birth (wks) | 40 | 41 | 41 | 38 | 37 | 40 | 39 | 36 | 37 | 39 | 40 | 38 |
| Pregnancy #2 | 34 | | | 42 | 33 | 40 | | | | 40 | | 37 |
| Pregnancy #3 | | | | 34 | | 34 | | | | | | |
| Delivery: SVD or C/S | SVD | SVD | SVD | SVD | SVD | SVD | SVD | SVD | SVD | SVD | SVD | SVD |
| Pregnancy #2 | N/A | | | SVD | SVD | SVD | | | | SVD | | SVD |
| Pregnancy #3 | | | | N/A | | N/A | | | | | | |
| Complications | ++labour face present. | fainted during labour | ++labour vacuum | Vacuum | Undiag. twins PTL PIH | mec. | Vacuum | PTL | ++labour | Forceps 4th tear mec. | Nil | PTL |
| AM Sickness: Yes/No | Yes-mild | Yes-mild | No | No | No | Yes-mild | No | No | No | No | No | No |
| Smoker: Yes/No | No | x 6 wks | No | No | No | No | No | No | No | Yes | No | No |
| Gender of child: M/F | F | F | M | M | M | M | F | F | M | M | F | M |
| Pregnancy #2 | | | | F | M-M | F | | | | M | | F |
| Breastfeeding: Yes/No | No | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes | No | No |
| Pregnancy #2 | No plans | | | No milk | Yes | Yes | | | | Yes | | No |
| | | | | No plans | | | | | | | | |
| Health of children | Healthy | Healthy | Healthy | Healthy | Healthy | Healthy | Healthy | Healthy | Healthy | Healthy | Healthy | Healthy |
| Birthweight (lbs/oz) | 6.9 | 8.8 | 7.4 | 7.8 | 6 lbs | 6.14 | 7.1 | 5.8 | 6.4 | 8.6 | 6.1 | 6.4 |
| Child #2 | | | | 7.3 | 3.9 | 8 lbs | | | | 8.2 | | 5.12 |
| Child #3 | | | | | 3.1 | | | | | | | |
| Methods of wt. control during pregnancy: R=Restriction E=Exercize S=Stimulants D=Diuretics P=Purging | E R | R | E R | R S D | D L E | None | E P | R E | R P | R | R | R P |

*Secondary Participants

**Participants currently Pregnant

## APPENDIX H

### Prompting Questions

(added after the first two interviews were analyzed)

1. How, if any, has social support affected or influenced your eating disorder?

2. Can you share with me how you negotiate eating during your pregnancy?

3. Some women have shared that they have found differences in way that they feel and how they are coping with their eating disorder and their pregnancy depending upon what phase of pregnancy they are currently in. Has this also been your experience?

   Is there any difference in the first trimester versus the second versus the third trimester? Postpartum?

   If there is a difference, can you describe it? Why do you think that it is so?

# APPENDIX I

## Canada Food Guide

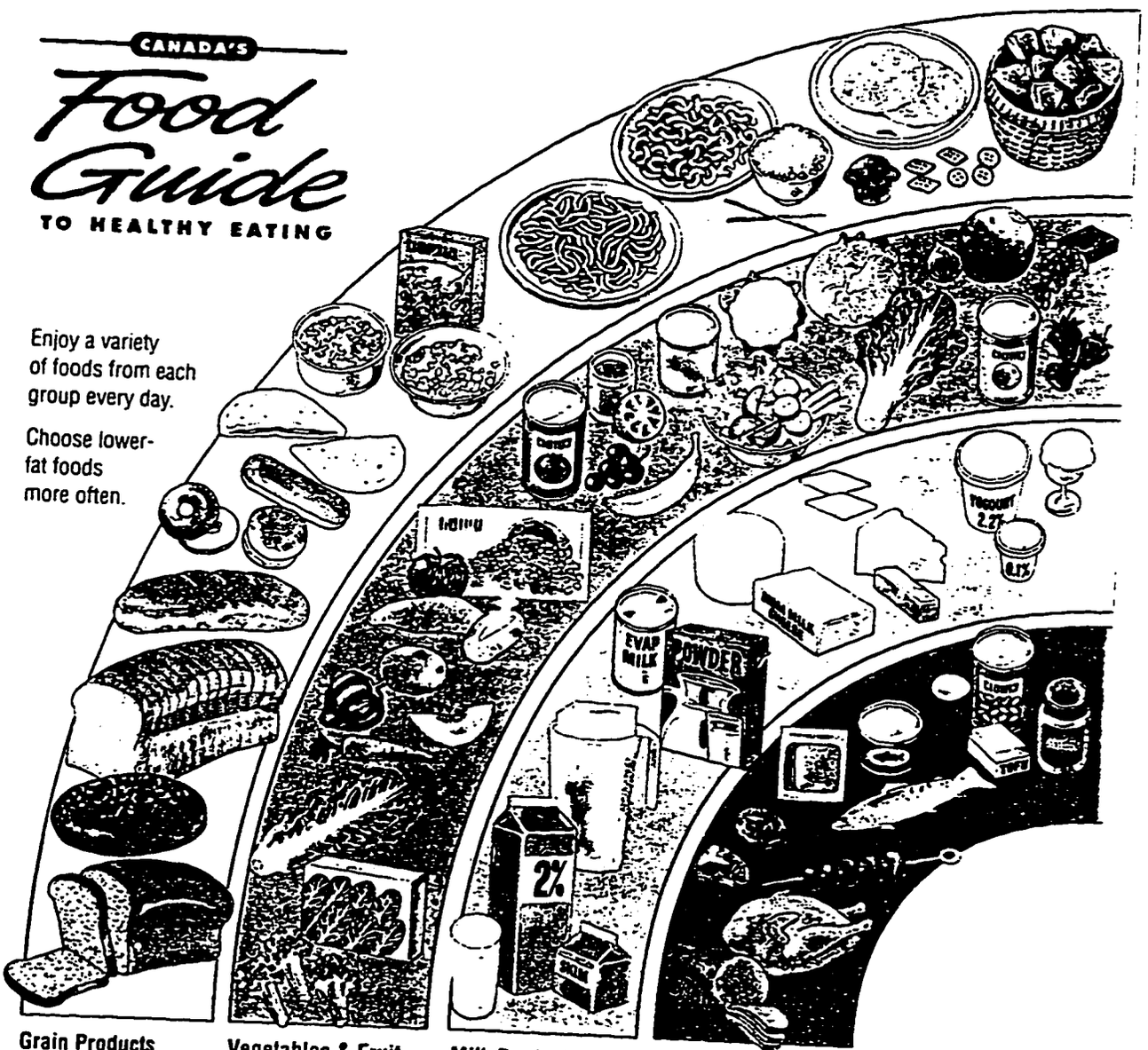
Healthy Canada

Health and Welfare Canada | Santé et Bien-être social Canada

CANADA'S

# Food Guide

TO HEALTHY EATING




**Grain Products**
Choose whole grain and enriched products more often.

**Vegetables & Fruit**
Choose dark green and orange vegetables and orange fruit more often.

**Milk Products**
Choose lower-fat milk products more often.

**Meat & Alternatives**
Choose leaner meats, poultry and fish, as well as dried peas, beans and lentils more often.

Canada

CANADA'S

# Food Guide

TO HEALTHY EATING

FOR PEOPLE FOUR YEARS AND OVER

## Different People Need Different Amounts of Food

The amount of food you need every day from the 4 food groups and other foods depends on your age, body size, activity level, whether you are male or female and if you are pregnant or breast-feeding. That's why the Food Guide gives a lower and higher number of servings for each food group. For example, young children can choose the lower number of servings, while male teenagers can go to the higher number. Most other people can choose servings somewhere in between.

### Grain Products

**5–12**

SERVINGS PER DAY

| 1 Serving | 2 Servings |
|---|---|
| 1 Slice | Hot Cereal 175 mL, 3/4 cup |
| Cold Cereal 30 g | 1 Bagel, Pita or Bun |
| | Pasta or Rice 250 mL, 1 cup |

### Vegetables & Fruit

**5–10**

SERVINGS PER DAY

| 1 Serving |
|---|
| 1 Medium Size Vegetable or Fruit |
| Fresh, Frozen or Canned Vegetables or Fruit 125 mL, 1/2 cup |
| Salad 250 mL, 1 cup |
| Juice 125 mL, 1/2 cup |

### Milk & Alternatives Products

SERVINGS PER DAY

| 1 Serving |
|---|
| 250 mL, 1 cup |
| Cheese: 3"x1"x1" 50 g; 2 Slices 50 g |
| 175 g, 3/4 cup |

### Meat & Alternatives

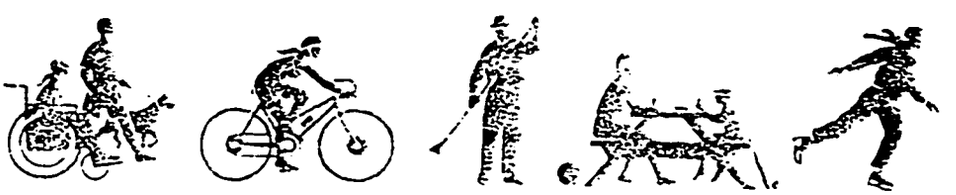
**2–3**

SERVINGS PER DAY

| 1 Serving |
|---|
| Meat, Poultry or Fish 50–100 g |
| Fish 1/3–2/3 Can 50–100 g |
| 1–2 Eggs |
| Beans 125–250 mL |
| 100 g, 1/3 cup |
| Peanut Butter 30 mL, 2 tbsp |

### Other Foods

Taste and enjoyment can also come from other foods and beverages that are not part of the 4 food groups. Some of these foods are higher in fat or Calories, so use these foods in moderation.



*Enjoy eating well, being active and feeling good about yourself. That's* VITALITY