



Pregnancy, birth outcomes, and parenthood in women/birthing parents with binge-eating disorder

Georgios Paslakis, MD

University Clinic for Psychosomatic Medicine and Psychotherapy, Ruhr-University Bochum – Bochum, Germany

Eating disorders (EDs) in women often manifest at an age that may coincide with the desire to have children. The presence of an ED, especially an active case, may be associated with unfavourable health outcomes for both mother/birthing parent and child, as evidence has shown. Besides malnutrition being the most crucial aspect, ED-associated behaviours may also be considered relevant to the development of EDs in children of mothers/birthing parents with EDs. The awareness of the potential for an ED to cause harm to the developing baby may be painful for women with an ED seeking to become pregnant. It therefore appears important for healthcare providers to be able to create the space in which women wishing to become mothers/parents will feel comfortable to openly bring up their thoughts and feelings and receive adequate support; it is not about undermining or discrediting the wish and efforts to bring children into the world, but to make sure that mothers with EDs and their children are safe in the process.

All types of EDs (especially anorexia nervosa, bulimia nervosa, and binge-eating disorder (BED)), including their sub-clinical manifestations, bear the potential of decreasing fertility and interfering with fetal and infant development due to malnutrition, binge-eating episodes, self-induced vomiting, abuse of laxatives, excessive activity, etc. (Dörsam et al. 2019; Watson et al. 2017). In BED, somatic comorbidities like high blood pressure or diabetes may exert additional negative effects on the course of pregnancy. Data on the prevalence of EDs in pregnant women are scarce. Howard

et al. (2018) found a prevalence of 2% for EDs in women in their early pregnancy, but numbers may differ depending on study protocols and cohorts under investigation. Another study reported a lifetime prevalence of 15.35% for EDs in pregnant women; among these women, 1.7% reported a lifetime prevalence for BED (Bye et al. 2020). The new onset of BED in pregnancy has been observed especially in women of lower socio-economic status (Bulik et al. 2007). Easter et al. (2013) reported that 8.8% of the pregnant women in their investigation regularly engaged in binge-eating behaviours.

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Evidence has shown that a significant proportion of women succeed in controlling ED symptoms during pregnancy or even achieve remission, for which there are multiple possible explanations, e.g., being motivated by the needs of the unborn child (Paslakis and de Zwaan 2019); at the same time, relapse in the ED is as relevant following birth (Sollid et al. 2021). In mothers with BED, 45% have been

shown to have overcome their ED at 18 months following birth (Knoph et al. 2013). On the other hand, evidence has shown that the physiological as well as the mental and emotional challenges that women face during pregnancy may be accompanied by the re-activation of an ED in those in recovery, or even the new onset of an ED; meanwhile, those who get pregnant while struggling with an ED may experience clinical deterioration (Easter et al. 2013; Easter et al. 2015). Fear of gaining weight, actual weight gain during pregnancy, but also higher pre-pregnancy BMI appear to be factors linked to disordered eating during pregnancy (Baskin et al. 2021; Savard et al. 2021).

The associations between EDs on the one hand, and pregnancy complications, adverse birth outcomes, and long-term consequences on the other, are well documented (e.g., Popovic et al. 2018; Mantel et al. 2020). Examples include increased vomiting, risk of bleeding, and higher rates of preterm birth. In addition, EDs are often comorbid with other psychiatric disorders like depression and anxiety, which by itself may increase the risk of postpartum mood and anxiety disorders as well as complications and unfavourable birth outcomes. Regarding BED, higher rates of miscarriage, longer durations of labor, higher frequency of caesarean sections, and large-for-gestational-age (LGA) newborns have been described (Weissmann-Brenner et al. 2012; Linna et al. 2013; Linna et al. 2014; Bulik et al. 2009; Eik-Nes et al. 2018; Watson et al. 2017). However, the evidence is not unambiguous as some studies have not shown associations like the ones described above (Watson et al. 2017), while at the same time the overall data do not provide evidence for inferences with ED-specific risk factors. Women with EDs can also struggle significantly with breastfeeding/feeding their child and with modelling a positive relationship with food. Finally, the EDs of mothers are a well-documented risk factor for the emergence of EDs in children (e.g., Bould et al., 2015; Ziobrowski et al., 2019), as also described for the case of BED (Lydecker and Grilo 2017). Communication

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and interaction patterns may be held accountable for observations of the kind, including higher overall parenting stress, raised concerns about children's weight, and conflicts regarding meal intakes in conjunction with mothers with EDs.

On occasion, it might be challenging to differentiate between the changes in eating routines, occurrence of cravings, and preoccupations with food and weight that frequently turn up during pregnancy and the symptoms giving notice of an ED. Healthcare providers most probably treat a great number of women with EDs who, however, are often secretive about their ED symptoms during pregnancy (Paslakis and deZwaan 2019; Bye et al. 2018). This might happen for reasons such as shame, fear of judgement, or even fear of being deemed an “unfit” parent and child protective services getting involved, and only stresses the responsibility on the side of healthcare professionals to create safe spaces for their clients to openly bring up all issues of concern. This is all the more important since many healthcare professionals do not feel well enough prepared to address ED issues or do not think that this lies within their duties (Leddy et al. 2009). All healthcare professionals treating women with BED expressing their wish to be a parent need to acknowledge and validate that wish. They need to be educated about how to help decrease reservations and fears when dealing with women with BED or EDs in general. Individuals with larger bodies face weight bias and stigmatization within the context of health care settings and these negative experiences might exacerbate emotional eating and ED-related symptoms (Incollingo-Rodriguez et al. 2019). It is critical for healthcare professionals to reflect upon their own attitudes regarding body shape and weight that may influence interactions with larger-bodied pregnant people with BED. Considering the evidence that EDs may impact conception, pregnancy, birth, and children's development, a sensitive approach and an eye-to-eye accompaniment may help women with BED face the challenges associated with having children and having to deal with an ED at the same time.

Pregnant people with BED are encouraged to recognize and accept that there are uncontrollable aspects to pregnancy and birth, which calls for learning to cope with uncertainty and trustfully embracing change. This is admittedly a hard task, as it requires dealing with aspects like body image, perfectionism, internalized stigma and associated feelings of shame and guilt, sometimes the urge to socially withdraw, or even the sudden emergence of negative childhood

memories. Psychotherapy is the method of choice when it comes to dealing with the profound impact that pregnancy and parenthood may represent for women with BED. Ideally, as part of an interdisciplinary plan, women with BED who plan to become pregnant, are pregnant, or have become parents and are concerned about their eating behaviours are able to find reliable support in a variety of disciplines, such as GPs, gynecologists and obstetricians, psychiatrists and specialists in psychosomatic medicine, ED therapists, as well as dietitians and nutritionists (Paslakis and de Zwaan 2019). While screening for EDs in the prenatal care setting and emphasizing the value of consistent and adequate nutrition intake in preventing binge-eating episodes are

important, it is essential to maintain a focus on clients' overall health (which includes their psychological wellbeing) during pregnancy, rather than just their weight. Professionals might need to reconsider whether it is truly important to weigh clients; if it is medically necessary to assess weight, it should be made sure that it is done non-judgmentally and with utmost sensitivity (i.e., in a private space, allowing the client face away from the numbers on the scale if they wish). Considering these aspects can only strengthen the alliance between health care professionals and parents (-to-be), leading to better health outcomes for parents and their offspring.

Note: We refer to “women” throughout the article mostly because research so far has not adequately addressed the fact that not all people who can get pregnant and give birth identify as women, i.e., non-binary people. However, we would like to acknowledge that people of other genders can also experience pregnancy and birth.

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