Disordered or [Ab]normal Eating in Pregnancy

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**Introduction**

Pregnancy is a powerful biopsychosocial event that involves a multitude of rapid changes to a woman’s body, eating patterns, social functioning, and self identity – most of which are largely outside her control.

Although it is well known that eating disorders and disordered eating disproportionately affect young women often during childbearing years, historically, scientific understanding of the intersection between pregnancy and eating disorders has been poor.

Overall, it is known that pregnancy can impact an eating disorder in three main ways:

1. Pregnancy may function as a catalyst for remission
2. Pregnancy may exacerbate existing ED symptoms
3. Pregnancy may act as a trigger for relapse

However, pregnancy may also serve as a period of risk for unaffected women, acting as precipitating event for the development of disordered eating behaviours in women without a lifetime history of an eating disorder.

**How common is it?**

Data from several longitudinal prospective birth cohort studies suggest at least 1 in 20 women suffer from some type of eating disorder during pregnancy, with this estimate not considering sub-threshold disordered eating concerns.

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**The Problem**

It is currently estimated that only 38% of antenatal providers screen for disordered eating in pregnancy. This is unfortunate as antenatal providers are well-positioned to screen for, and potentially identify, disordered eating behaviours – pregnancy is one of the rare occurrences women are engaged in consistent and systematic health care.

**Possible Barriers**

1. **Conceptual Issues**
   - No existing definition for what constitutes disordered eating in pregnancy and how this differs from pregnancy-appropriate abnormal eating? This is particularly problematic as pregnancy can mask symptoms of disordered eating.

2. **Resource Issues**
   - No pregnancy-specific ED screening instrument currently exists. Empirical literature and clinical guidelines currently recommend practitioners use ED screening instruments designed for non-pregnant populations, which are not appropriate in the context of pregnancy (i.e., have never been validated in pregnant samples).

3. **Stigma Issues**
   - Eating disorders tend to attract a high level of volitional (blame-based) stigma. This stigma is likely to be exacerbated in the context of pregnancy. As a result, voluntary symptom disclosure is likely to be poor.

**Study Objectives**

- Explore how experts define disordered eating in pregnancy?
- Determine how experts distinguish disordered eating behaviours from [ab]normal eating behaviours during pregnancy?
- Understand expert perceptions of existing screening practices and methods

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**Methodology**

**Delphi Technique**

- Identify problems/priorities
- Round I
- Round II
- Round III
- Feedback
- Feedback
- Feedback
- Final Report
- End of sequence

**Participants**

Participants were 32 international eating disorder experts (from 5 countries) with an established interest in women’s health or perinatal psychiatry from the fields of psychology, psychiatry, obstetrics, general medicine, midwifery, and dietetics (28 women, 3 men). There was an average of 19 years professional experience and 14.50 years of experience in the speciality field of eating disorders. The majority of panel members reported they were involved in both research and clinical practice.

**Preliminary Findings (at the end of Round II)**

Panel members believed current prevalence rates of EDs in pregnancy are under-estimated due to various factors, in particular they do not include sub-threshold disordered eating.

Panel members considered the DSM-5 criteria for EDs to be somewhat acceptable in the context of pregnancy; however, strongly recommended the inclusion of a pregnancy specifier for weight-related criteria.

Panel consensus was reached for 56 of the 67 potential symptom attributes, with at least half of these specific to the pregnancy context.

Panel consensus was reached for 27 of the 33 potential foci distinguishers.

Panel members believed screening for disordered eating should be a routine component of antenatal care (i.e., occur for every woman), with a preference for brief screening tools.