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The Experience of Pregnant Women in Remission from Anorexia Nervosa

Meghan Butcher
Antioch University of New England

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by

Meghan Butcher

B.A., Keene State College, 2013
M.S., Antioch University New England, 2016

DISSERTATION

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The undersigned have examined the dissertation entitled:

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by

Meghan Butcher

Candidate for the degree of Doctor of Psychology
and hereby certify that it is accepted*.

Dissertation Committee Chairperson:
Kathi A. Borden, PhD

Dissertation Committee members:
Martha Dunn, PsyD
Porter Eagan, PsyD

Accepted by the
Department of Clinical Psychology Chairperson
Lorraine Mangione, PhD

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* Signatures are on file with the Registrar's Office at Antioch University New England

Dedication

To my Mom and Dad, for giving me my wings.

Acknowledgements

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Lastly, I would like to thank the women who participated in this study. I will be forever inspired by your bravery and vulnerability. Your willingness to speak about your experience is a wonderful gift to this field, and to the women out there who will benefit from your story.

Table of Contents

Abstract

This qualitative study explored the subjective experience of pregnant women in remission from Anorexia Nervosa (AN). This subject matter is of importance due to the high relapse rates of AN, the ability for women to become pregnant while in remission from AN, the significant physical and emotional tolls of pregnancy, and the known dangers of AN behaviors during pregnancy. Prior to this study, minimal research had been conducted pertaining to the experience of women who became pregnant while in remission from AN. This study utilized Interpretative Phenomenological Analysis (IPA) to inform interpretation of narrative responses collected through semi-structured interviews. Participants consisted of three women between the ages of 26 and 32 who self-identified as having become pregnant within the past five years while in remission from AN. The outcome of the analysis resulted in the following themes: (a) *control* as a mechanism of AN, (b) experiences of lack of agency over body and health of pregnancy, (c) rigidity vs. restriction: lingering AN voice and inflexibility, (d) pregnancy positively impacts some aspects of relationship with food and body image, (e) environmental stressors impair level of engagement in self-care behaviors, (f) social relationships have significant influence on formation of self-perception and health-maintenance behaviors, and (g) history of AN minimized during routine prenatal medical care. Exploration of the findings in the context of existing research brings to light the possibility that aspects of pregnancy trigger women's desires to maintain or regain control, and that efforts to do so may mimic behaviors that are characteristic of AN. Additionally, the results shed light on the possibility that "rigidity" is a characteristic of AN that can remain post remission and manifest in inflexible behaviors surrounding food and exercise. Lastly, the results suggest that there is a heavy reliance on medical providers to monitor and manage the residual effects of a prior AN diagnosis among this demographic, and suggest

that the role of mental health providers should be more prominent in the prenatal care course.

Keywords: Anorexia Nervosa, remission, rigidity, agency, pregnant women in remission

The Experience of Pregnant Women in Remission from Anorexia Nervosa

In this study, I explored the subjective experience of pregnancy through participants' own narratives as provided in response to interview questions designed to encourage introspection. In the first part of this paper, I define Anorexia Nervosa, and provide context surrounding its associated features, debilitating effects on physical and mental health, and chronic nature. I then review the literature pertaining to the dangers of maternal AN during pregnancy, as well as the research that has been conducted surrounding the impact of pregnancy on maternal eating disorder symptomology. Lastly, I summarize the main findings of a meta-ethnographic review of literature surrounding the subjective experience of pregnancy among women with an eating disorder.

In the Method section, I first discuss the purpose of applying a qualitative research design to this study, and then describe the method of analysis: Interpretative Phenomenological Analysis (IPA). Next, I discuss the method of participant recruitment and selection, the process of data collection, and the interview prompts for data collection, taking care to explain the special considerations paid to confidentiality, consent, and ethical guidelines. Lastly, I describe the step-by-step application of IPA in the process of data analysis, and discuss the systems put into place in consideration of validity.

In the Results section, I first describe the participant demographics. I then present and describe the seven superordinate themes and constituent emergent themes that arose during data analysis. I conclude with the Discussion section where I provide a discussion of my own relationship to the topic of interest followed by an overview of the findings. I then explore the themes in the context of existent literature and discuss clinical implications and recommendations for each. Lastly, I present the limitations of this research study, make

recommendations for future research, and conclude with final thoughts.

Literature Review

Understanding Anorexia

One in 200 American women suffer from Anorexia Nervosa ("Eating Disorder Statistics," 2014; "Eating Disorder Types and Symptoms," 2016), a disorder that is characterized by a relentless pursuit of thinness and control, with onset most often occurring during adolescence ("Eating Disorder Statistics," 2014; "Eating Disorder Types and Symptoms," 2016). The American Psychiatric Association's (2013) criteria for AN include extreme fear of gaining weight leading to the restriction of energy intake as a way of achieving and maintaining low body weight. Those meeting the criteria for AN maintain a minimal and abnormal weight in light of their age, sex, and developmental trajectory. The AN diagnosis is categorized into two types: (a) the restricting type, and (b) the binge eating and purging type. The restricting type involves weight loss and maintenance primarily through dieting, fasting, and/or excessive exercise (American Psychiatric Association, 2013). The binge eating and purging type involves weight loss and the maintenance of low weight primarily through binge eating and purging, such as self-induced vomiting, or use of laxatives, diuretics, or enemas (American Psychiatric Association, 2013).

Associated features and comorbidity. Features associated with the diagnosis of AN include, but are not limited to, inflexible thinking, overly restrained emotional expression, feelings of ineffectiveness, and a strong desire to control ones' environment (American Psychiatric Association, 2013; Grisham, Touyz, Froreich, & Vartanian, 2016). Strong theoretical links between issues of control and eating pathology have been demonstrated among narratives of those who suffer form eating disorders, wherein food and weight have been described as areas

of life in which individuals feel able to exert control in the face of difficulty or distress (Arkell & Robinson, 2008; Button & Warren, 2001; Grisham et al., 2016; Shaffer, Hunter, & Anderson, 2008). The disorders that most commonly co-occur with AN include bipolar, depressive, and anxiety disorders. Individuals with restricting type AN also commonly report obsessive-compulsive features both related and unrelated to food, body weight, and shape (American Psychiatric Association, 2013).

The effects of anorexia can be debilitating. The toxicity of the symptoms associated with AN put sufferers in great danger. AN is associated with the highest mortality rate of any mental illness in America ("Eating Disorder Statistics," 2014). The National Association of Anorexia Nervosa and Associated Disorders reports that 5–10% of people suffering from AN die within 10 years after developing the disease, and 18–20% of those suffering from the disorder will die after 20 years ("Eating Disorder Types and Symptoms," 2016).

AN puts sufferers at high risk for a plethora of both physical and mental health complications. These physical health risks include, but are not limited to, cardiovascular complications, electrolyte abnormalities, anemia, bone loss, gastrointestinal problems, and kidney problems ("Anorexia Nervosa," 2012; Katzman, 2005). In addition, symptom severity of existing mental health disorders, including depression, anxiety, personality disorders, obsessive-compulsive disorders, and substance misuse, may increase following the onset of AN ("Anorexia Nervosa," 2012).

AN not only impacts the sufferers, but those who care for them as well. Several studies have demonstrated that AN caregivers are at increased risk for clinical anxiety and depression due to the stress that caretaking imparts on them. Raenker et al. (2013) examined how caregivers cope practically and emotionally with caring for individuals with anorexia nervosa who require

intensive hospital care. The participants were 267 caregivers assessed for objective burden (time spent with caregiving and number of tasks), subjective burden (psychological distress), and social support. The results indicated that time spent caregiving was associated with increased caregiver distress that was fully mediated by caregiver burden. This study demonstrates that AN not only has a negative impact on the sufferers, but causes distress in those close to them as well.

Anorexia is a chronic disorder. A person suffering from AN can reach either partial or full remission. A person in partial remission does not meet DSM-5 Criterion A (low body weight, for a sustained period). However, a person in partial remission still meets either Criterion B (intense fear of gaining weight or behavior that interferes with weight gain), and/or Criterion C (disturbances in self-perception of weight and shape; American Psychiatric Association, 2013). A person in full remission meets none of the criteria for the disorder for a sustained period of time (American Psychiatric Association, 2013).

Individuals in remission from AN remain at significant risk of relapse, with studies estimating a relapse rate between 30% and 50% (Carter, Blackmore, Sutandar-Pinnock, & Woodside, 2004; Herzog et al., 1999; Pike, 1998). Carter et al. examined the rate, timing, and prediction of relapse in AN following weight restoration in a specialized inpatient treatment program. The participants were 51 consecutive, first-admission AN patients who were weight restored following inpatient treatment. Follow up assessments were conducted a median of 15 months post discharge, with relapse of AN being defined as <17.5 Body Mass Index for three consecutive months. Results revealed the overall rate of relapse among participants at 35%, and identified the period of highest risk for relapse as 6–17 months after discharge. High relapse among those treated for AN underscores the importance of continued support and monitoring of those who have entered into remission.

A history of attempted suicides, previous specialized treatment for an eating disorder, excessive exercise immediately after the completion of treatment, and residual concern about shape and weight at discharge have been noted as significant predictors of relapse (Carter et al., 2004). Additionally, the severity of the presence of obsessive–compulsive symptoms at the onset of AN, including washing compulsions and ruminations, has been noted to be a predictor of relapse (Carter et al., 2004). Additional research suggested that lower dietary energy density scores (a score taking into account the caloric density and weight of food consumed) as well as a lower dietary variety score (a score taking into account the variety of foods/drinks consumed) may be associated with poor outcome in recently weight-restored women with AN (Mayer, Devlin, Attia, & Walsh, 2012; Schebendach et al., 2008).

Existence of some symptoms after remission. Whereas some individuals are able to achieve complete remission of AN symptoms once weight restoration is achieved, it is well documented that many individuals who achieve weight restoration continue to display cognitive distortions surrounding food, weight, and body image, as well as excessive dietary restraint (Clausen, 2004; Espindola & Blay, 2013; Fitchter, Quadflieg, Crosby, & Koch, 2017; Foerde & Steinglass, 2017; Pike, 1998). Clausen (2004) examined whether the time to remission varied for different eating disorder symptoms in 35 Anorexic patients and 30 Bulimic patients who had an initial assessment and consequent treatment at the Eating Disorders Centre located at Aarus University Hospital. All patients were diagnosed with an eating disorder that ranged from moderate to severe according to criteria in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994). The analyzed data were gathered through the Longitudinal Interval Follow-Up Evaluation of Eating Disorders (LIFE-EAT; Keller et al., 1987), which also included detailed questions on symptoms from the

Eating Disorder Examination (Fairburn & Cooper, 1993) administered two and a half years after baseline. Results revealed that weight restoration occurred before the remission of psychological symptoms of anorexia. Non-purging compensatory behavior (restricted eating, fasting, and intense exercise) and obsession with weight and shape were the last symptoms to remit among participants.

Dangers of Anorexia Nervosa During Pregnancy

Although many women who suffer from AN have difficulty becoming pregnant due to amenorrhea, regular periods and fertility will usually resume within six months of achieving adequate body weight (Golden et al., 1997). Therefore, it is possible for women with a history of AN to get pregnant while in remission from the disease. If AN symptoms persist during pregnancy, both mother and baby are at risk for health complications. Physical consequences for mothers include poor weight gain, increased risk of miscarrying, and increased need for cesarean delivery (Katz & Vollenhaven, 2000). Additionally, a study reporting pregnancy complications and neonatal outcomes for 49 live births in a group of women with eating disorders revealed that mothers with eating disorders were at a higher risk of developing postpartum depression compared to the general population (Franko et al., 2001). While the general population of women with postpartum depression is estimated to be between 3% and 12%, the women with eating disorders who were presented in this study reported more than three times that rate (Franko et al., 2001).

The health of a fetus can also be greatly impacted when carried by a woman who suffers from AN. Unfavorable fetal outcomes include intrauterine growth retardation, low birth weight, congenital anomalies, microcephaly, increased risk for premature birth and higher perinatal mortality (Kouba, Hallstron, Lindholm & Hirschber, 2005; Lowes, Kopeika, Micali, & Ash,

2012). Premature and low birth weight infants born to women with AN have also been shown to be at increased risk of experiencing hypoglycemia, hypothermia, increased risk for infection, respiratory problems and feeding difficulties (Katz & Vollenhaven, 2000; Kouba et al., 2005; Lowes et al., 2012). These detrimental complications can seriously impact an infant's early developmental health.

Previous Research Surrounding Pregnancy and AN Symptomatology

Given the danger of AN symptoms during pregnancy—as well as the high relapse rates of the disorder—it is crucial that both the medical and mental health communities understand the experience of women who become pregnant while in remission. Research has suggested that the profound developmental changes that occur among women during pregnancy can lead dormant psychological issues to surface (Franko & Walton, 1993). For example, it has been documented that women often experience conflict pertaining to their bodily changes during pregnancy (Bailey & Hailey, 1987). Internal conflict surrounding one's body image is a large factor in the development and maintenance of eating disorder pathology (Johnson, 1991). Limited research has been done surrounding pregnant women with a history of eating disorders in general (i.e., not specific to AN). Results from existent research are varied, but do indicate that pregnancy is associated with body dissatisfaction and a resurgence of symptoms among those with a past history of the disorder (Kouba et al., 2005; Micali, Simonoff, & Treasure, 2007).

Kouba et al. (2005) examined pregnancy and neonatal outcomes in 49 women with past or current eating disorders as compared to a control group of 68 women. The participants were 24 women previously diagnosed with AN, 20 women previously diagnosed with bulimia nervosa, and five women previously diagnosed with eating disorders not otherwise specified. Prenatal complications, mode of delivery, and neonatal outcome variables were analyzed.

Among the women in the study, 22% of subjects with a previously diagnosed eating disorder had a verified relapse. These women were also at increased risk of hyperemesis and delivered infants with significantly lower birth weight and smaller head circumference as compared with the control group. Their risk was also higher than that of the controls for delivering infants who were small for their gestational age and who experienced microcephaly. These results indicate that women with a history of eating disorders are at especially high risk for relapse, and thus are at risk for a range of negative outcomes during pregnancy.

Micali et al. (2007) examined the impact of pregnancy on eating disorder symptoms using data from a large, prospective, community-based cohort study. Participants in this study were 12,254 pregnant women who were divided into three groups: (a) those with a recent or past history of eating disorders, (b) those who were obese before pregnancy, or (c) those from a general population group without a history of eating disorders. Self-induced vomiting, laxative use, exercise behavior, appraisals about weight gain during pregnancy, dieting, shape and weight concern before and during pregnancy were evaluated. Results from this study revealed that those women with a recent eating disorder dieted, used laxatives, reported self-induced vomiting and exercised more than other groups during pregnancy. This group was also more likely to report disordered cognitions in pregnancy while their weight and shape concern remained high throughout. These results suggest, at the very least, that negative cognitions about weight gain typically persist during pregnancy among women with a history of disordered eating.

Though research that has demonstrated the presence of ED symptoms among women with a history of AN during pregnancy, there is no uniform response that occurs when a woman with an eating disorder becomes pregnant. Research has demonstrated varying results, including the reduction of eating disorder behaviors during pregnancy (Crow, Agras, Crosby, Halmi, &

Mitchell, 2008; Tierney, Fox, Butterfield, Stringer & Furber, 2011) and, less commonly, the complete cessation of disordered eating behaviors during pregnancy (Tierney et al., 2011). Therefore, the fluctuations in findings support the need for continued investigation into the experience of pregnancy among women who have a history of AN to better understand the variables that impact disordered eating behaviors during the prenatal period.

The Subjective Experience of Pregnancy Among Women with Eating Disorders

In perhaps the most thorough example of research conducted thus far, Fogarty, Elmir, Hay, and Schmied (2018) shepherded a meta-ethnographic review of existing research pertaining to the experience of pregnancy among women with an eating disorder. Researchers conducted an online search of existent literature using keywords relevant to pregnancy and eating disorders, which led to the inclusion of 11 papers in the review. Studies were published between 1986 and 2015, the majority of which were from the United States and the United Kingdom. Sample size was a median of six across all studies. The combined sample included a total of 94 women aged between 21–45 years old. Twenty-two women were pregnant and 72 had given birth at the time of the interview. The array of eating disorder diagnoses included 22 women with anorexia nervosa (AN); 17 with bulimia nervosa (BN); 10 with BN, binge eating disorder (BED), or eating disorder not otherwise specified (EDNOS); 34 with an eating disorder (type not specified); and 11 with AN or BN (breakdown not specified).

A qualitative synthesis of the 11 papers resulted in the identification of two overarching themes, one pertaining to the pregnancy period, and one pertaining to the postnatal period. With regard to the prenatal period, the theme that emerged was “Navigating a ‘New’ Eating Disorder.” Results indicated that women experienced tumultuous changes in their relationship with their eating disorder. Women grappled with the bodily changes that pregnancy brought about, and

reported dissatisfaction and close monitoring of their weight gain. Later in pregnancy, women reported that they began to feel more positively about their body, as it became clearer to both themselves and others that they were obviously pregnant, not "fat." Women also experienced difficulty regulating their emotions in the face of the constraints that pregnancy placed on their usual methods of control (i.e., exercise, food, purging, binging, and/or restrictions). Women reported feeling overwhelmed and worn down by the consistent chatter of their inner eating disorder voices as they struggled to quiet them in the absence of their usual methods of control.

Another finding was that women experienced an ongoing 'tug-of-war' between managing the needs of their eating disorder and the needs of their unborn child. The conflicting nature of these desires caused women to 'fine-tune' their behaviors in attempt to achieve both. The outcome of this fine-tuning often resulted in certain alterations in their eating behaviors (e.g., moderation or a decrease in severity of problematic eating behaviors, rather than a complete relinquishing of their disordered behaviors). At the very least, this study highlights how pregnancy transforms the relationship that women have with their eating disorders, and how the internal battle between the needs of their eating disorder and needs of their unborn child consume much of the pregnancy experience.

Statement of Purpose and Present Study

The goal of this study was to establish a greater level of understanding of how pregnant women in remission from AN experience their pregnancy. Research has provided evidence indicating that the profound changes that take place during pregnancy can lead dormant psychological issues to resurface, and similarly that many pregnant women in general report internal conflict surrounding their body image. Research has also provided scientific evidence surrounding the high relapse rate of AN, and the detrimental risks of active AN symptomology

during pregnancy. Simply stated, the high relapse rates of AN, the ability for women to become pregnant while in remission from AN, and the known dangers of AN behaviors during pregnancy suggest great importance in understanding the experience of this group. Furthermore, women who are suffering from AN symptoms during pregnancy are not only putting themselves and their babies at physical risk, but they are also at increased risk for postpartum difficulties. However, minimal attention has been given to the subjective experience of women who become pregnant while in remission from AN. Therefore, my research question was as follows: *What is the experience of a pregnant women in remission from AN during pregnancy?* It was believed that the findings of this study would expand upon the previously identified mechanisms behind instances of relapse during pregnancy, as well as provide insight into potential intervention opportunities.

Method

Research Design: A Phenomenological Qualitative Approach

This study was conducted using a phenomenological qualitative research paradigm to explore the subjective experience of pregnancy among women with a history of AN. Interpretative Phenomenological Analysis (IPA; Smith, Flowers, & Larkin, 2009) was utilized to guide the study. Through semi-structured interviews, individuals were encouraged to tell their own personal narrative about their experience of pregnancy, and were asked to consider topics of meaning making throughout their account. The IPA approach aims to examine the ways in which people make sense of their major life experiences (Smith et al., 2009). By utilizing this method, I was able to deeply explore each participants' unique experiences by examining how she made sense of different aspects of her pregnancy. I was then able to extract themes from within the gathered data, ultimately leading me to develop a deeper understanding of the experience of

pregnancy as a whole for this demographic.

Interpretative Phenomenological Analysis (IPA)

Characteristics and theoretical underpinnings. Phenomenology, hermeneutics, and idiographic perspective are the theoretical perspectives that are central to IPA. *Phenomenology* can be understood as the philosophical approach to the study of human experience. Though it focuses on all aspects of human experience, it is the ones that matter the most to human beings that are most closely attended to. Phenomenology is concerned not with predefining or overly generalizing the human experience, but with understanding the experience of interest in its own terms (Smith et al., 2009).

Hermeneutics can be understood as the theory of interpretation. Within IPA, research participants are asked to attempt to make sense of what is happening to them. This, in itself, is an interpretative process, and thus informed by hermeneutics (Smith & Osbourne, 2003). Smith et al. (2009) posit that the IPA researcher engages in a "double hermeneutic process." In order for a researcher to gain access to the experiences that hold meaning for research participants, the researcher must interpret the account from the participants as a means of understanding it. Thus, the researcher is trying to interpret the participant's own interpretation of their experience. Though this suggests that the researcher and participant are employing similar meaning-making strategies in the process of IPA, the researcher is doing so in a more systematic and conscientious manner than the participant. In doing so, emphasis is placed on extracting the participants' first-person account of their subjective experience, while researcher interpretation is seen as a second-order task.

The third tenet of IPA is the commitment to the *idiographic* approach. The idiographic approach can be understood as one that is committed to detail and in-depth analysis with a focus

on how particular experiences are understood from the perspective of particular people, in particular contexts. Smith et al. (2009) point out how the idiographic approach is in contrast to the 'nomothetic' approach (i.e., focused on making claims for the group or population level) that is typical of most psychological research. IPA studies commonly have a small number of participants, and are not focused on making broad generalizations, but rather on gathering personally unique perspectives on specific areas of human experience (Smith et al., 2009). The idiographic approach does not inherently avoid generalizations, but rather comes to make them through a much more focused lens that provides access to discrete information that may be applicable to the greater population of interest.

Rationale of using IPA. As previously stated, IPA utilizes an idiographic and interpretative approach to gain a better understanding of lived human experience. Thus far, much of the research conducted surrounding AN and pregnancy has used a nomothetic approach. Studies have largely included participants in different stages of a broad range of eating disorder diagnoses (i.e., active, recovery, remission, undefined past history, etc.) to look at the resurgence of symptoms during pregnancy on a more global level. The clinical applicability of said research is hindered by the limitations of nomothetic inquiry, one of which being the generalization of findings across very different eating disorder diagnoses. Additionally, within the extant research, minimal attention has been paid to the facilitating factors behind instances of relapse or remission of symptoms during pregnancy.

IPA's theoretical underpinnings support the epistemological position of my research question, that is, to understand the experience of pregnancy from the perspective of women who are in remission from AN. This method allowed for an in-depth examination of this experience at the individual level, while also supporting the development of fine-grained descriptions of

themes and patterns of meaning across cases and reflective of the larger group as a whole. This twofold outcome supported my effort to more closely attend to the factors surrounding the variability that has been demonstrated in women's responses to pregnancy (i.e., worsening of symptoms, improvement in symptoms, relapse, remission) within this group.

Participants

Purposeful convenience sampling. As is theoretically consistent with the qualitative paradigm, participants were selected purposively so as to promote a homogenous sample that would allow for insight into the particular experience being studied (Smith et al., 2009). Recruitment took place through flyer advertisements in obstetrician offices, family health care facilities, internal medicine facilities, and hospitals in New England and New York City. These flyers described the purpose of the study and the method to be used, as well as participant criteria (see Appendix B).

Recruitment was also done through referral, as I contacted obstetricians, primary care physicians, mental health clinicians, and eating disorder specialists within New England and New York to advertise the study and recruit participants. Providers who were contacted were comprised of my own professional contacts in the medical and mental health field, and newly identified contacts found through the "snowballing" method (i.e., professional to professional introduction). Participants made initial contact with me via phone or email after having seen the flyer or having been referred by a provider. Following the initial contact, a phone interview was conducted where I provided additional information about the study, determined whether or not the participants met the inclusion criteria, and answered any questions about the study. I then scheduled the interview with the participants who met the inclusion criteria and wished to proceed.

Inclusion and sample size. Participation was completely voluntary, and no incentive was offered to participants for being part of the study. Inclusion criteria included, (a) must be female between the ages of 18–35, (b) must have a history of clinically diagnosed Anorexia Nervosa, and (c) must have become pregnant in the last five years while in remission from Anorexia Nervosa. Participants were chosen without regard to ethnicity or socioeconomic status.

Smith et al. (2009) propose that a sample comprised of three to six participants generally provides sufficient data for the development of meaningful comparisons and contrasts within and between cases. For this study, I have limited my sample size to three participants. This was due, in part, to the challenges that I faced in recruiting additional participants, and the time that recruitment required. However, Smith et al. (2009) describe a three-participant sample size as "useful" given that it allows the researcher to conduct a detailed analysis of each case as well as conduct a subsequent microanalysis of similarities and differences across cases. Given the limitations of nomothetic inquiry that were previously discussed, I was confident in capping my sample size at three as it would enable me to immerse myself in the detailed analysis that IPA's idiographic commitment requires in order to capture the complexity of the human experience, while also providing room to analyze the relationships among participants' narratives.

Ethical Considerations, Informed Consent, and Confidentiality

Participants who met eligibility requirements for the study were sent a consent form (see Appendix C) via the postal service along with a stamped, self-addressed envelope. Participants were instructed to read through the informed consent form, provide their signature, and then send it back to me prior to their interview date. On the interview date, I reread the signed consent form to the participants, and spent time answering any questions that they had in order to ensure that they were comfortable with the interview process.

All participants were assured of their confidentiality and anonymity. All participants provided written consent for the audio recording of the phone interviews. In order to assure privacy, the audio recordings were password encrypted, and the device containing the recordings was physically stored in a locked safe when not in use. These audio recordings were kept in the safe until the completion of the dissertation and then destroyed. The audio recordings were transcribed verbatim in a password-encrypted document. Written notes that were taken during the interviews were transcribed digitally and kept in a password-encrypted document, while the hard copies of the notes were shredded immediately after transcription. To ensure anonymity, participants' names are not included on any documentation of interview dialogue. Instead, a pseudonym was assigned to each participant and was used as the method of identification throughout the research process. All of the documents pertaining to the interviews were stored on a password-encrypted computer that only I had access to.

The potential for minimal psychological harm existed because the study asked participants to discuss potentially sensitive details pertaining to their pregnancy. Participants were instructed not to answer questions that caused distress and to terminate their participation in the interview if they were in distress during the process. Participants were encouraged to seek professional mental health support if they were to find that their distress became too high or not manageable on their own. None of the participants expressed experiencing distress throughout the interview process.

Data Collection Methods and Interview Questions

Data were gathered through semi-structured interviews in order to allow for in-depth exploration of each participant's experience. Interviews took place over the phone, lasted for approximately 75 minutes, were digitally recorded, and then transcribed into text documents.

The interviews consisted of a series of both predetermined, uniform questions (see Appendix A), as well as organically produced questions that built on the participants' responses. The content of the interviews explored participants' (a) history with AN, including their transition into pregnancy; (b) body image satisfaction of dissatisfaction during pregnancy; (c) relationship with food; (d) relationship with exercise; (e) overall psychological well-being; (f) social support; and (g) access to healthcare. The combination of both uniform and organically produced follow-up questions throughout the interview enabled the participants to reflect on the general experience of their pregnancy, and left room for me to gather details specific to their unique narratives.

The Process of Data Analysis

Interpretative Phenomenological Analysis (IPA) was used to analyze the data gathered through the participant interviews. Through the use of the IPA method, I closely examined how each participant made sense of their unique experiences during pregnancy, with particular attention paid to their transition into pregnancy, body image satisfaction or dissatisfaction, relationship with food, relationship with exercise, overall psychological well-being, social support, and access to healthcare. Throughout the process of analysis and interpretation of the data, I attended to both the idiographic nature of each individual's narrative, while simultaneously considering the presence of unfolding thematic commonalities among the group. At the conclusion of the data analysis, I developed a detailed and cohesive narrative of the experience of the larger group as a whole through the careful analysis of patterns, commonalities, and discrepancies across each participant's account.

IPA analysis. There is no single prescribed method for IPA analysis; rather it can be characterized by a set of common processes and principles. Smith et al. (2009) describe the process of IPA as an iterative and inductive cycle. That is, there is not one linear and inductive

cycle. In the present study, I closely followed the approach that is suggested by Smith et al. (2009) which includes six distinct steps: (a) reading and rereading, (b) initial noting (c) developing emergent themes, (d) searching for connections across emergent themes, (e) moving to the next case, and (f) looking for patterns across cases. In addition to these steps, I utilized a secondary coder. I compared our independent results to improve the quality and rigor of the analysis by allowing for the incorporation of different perspectives, while decreasing the impact of my own biases (Liggett et al., 1994). Through this process, transcripts were coded utilizing a combination of the participants' claims and my own interpretation of the meaning of these claims. Lastly, superordinate themes and emergent themes were identified and summarized, and organized in a table for each participant that included direct quotes (Smith, Jarman, & Osborn, 1999).

Step 1: Reading and rereading. The first step of the analysis was done with the purpose of immersing myself in the original data to ensure that the participant became the focus of my analysis, rather than an impulsive reduction and synopsis of the information (Smith et al., 2009). To do so, I first listened to the audio recording of the interview in its entirety. Next, I listened to the audio recording again while manually transcribing it into text. Lastly, I reread the transcript in its entirety.

Step 2: Initial noting. The next level of the analysis involved examining the semantic content and language use on an exploratory level in order to produce a comprehensive and detailed set of notes on the data (Smith et al., 2009). As described previously, IPA has phenomenological roots, and thus it was important that I closely analyze any and all experiences that were described by the participant rather than sift through the data for particular meaning-units or pre-established themes. To ensure a thorough analysis of all data with

phenomenological and hermeneutic relevance, I carefully read through the transcript and made three different types of comments: (a) descriptive comments that focused on describing the specific content of what the participant had said, (b) linguistic comments that explored the participant's specific use of language, and (c) conceptual comments and questions of interpretation.

Step 3: Developing emergent themes. After having completed the initial noting of an interview transcript, I sifted through my notes in order to identify emergent themes. The purpose of this step of the analysis was to reduce the volume of the data for each participant, while still maintaining its complexity through the mapping of relationships, connections, and patterns within the initial notes (Smith et al., 2009). These themes were expressed as phrases and written in the right-hand margin.

Step 4: Searching for connections across emergent themes. The next step of the analysis involved mapping out how the emergent themes fit together (Smith et al., 2009). This step resulted in a set of superordinate (i.e., higher level) themes, that contained several emergent, relevant themes within them. For this process of analysis, I typed a list of the emergent themes identified in Step 3 in chronological order, and then moved the themes around to form clusters of related themes. The formation of superordinate and related emergent themes were derived through methods of abstraction (i.e., combining themes that are alike to create a superordinate theme); subsumption (i.e., turning emergent theme itself into a superordinate theme); polarization (i.e., analyzing oppositional relationships between emergent themes); contextualization (i.e., attention paid to the temporal, cultural, and narrative emergent themes); and function (i.e., attention paid to the specific function that emergent themes played within the interview process; Smith et al., 2009). Once the final list of superordinate and emergent themes

was identified, I compiled them into a table to both organize the data and have a visual representation of the gestalt that emerged from the analytic process.

Step 5: Moving to the next case. Steps 1 through 4 were repeated systematically for each subsequent transcript.

Step 6 Comparison to secondary coder: At the conclusion of Steps 1 through 5, I enlisted a peer from my doctoral program to be my second coder for this research. This coder was a 27-year-old Caucasian female and fifth-year PsyD graduate student. This coder utilized IPA in her own research and, as such, was well-versed in the process of analysis and the theoretical underpinnings of IPA. This coder replicated my process of analysis by closely following steps 1 through 4. Following the completion of the secondary coder's analysis, I compared my results to hers. There was a significant degree of agreement pertaining to superordinate and emergent themes between the secondary coder and myself, demonstrating coherence in understanding of the findings. More specifically, the quality and rigor of this methodological analysis and interpretation of data was improved by the allowance of the secondary coder's perspectives (Liggett, 1994). Additionally, by identifying the few areas of discrepancy between my findings and the secondary coder's, I was better able to identify areas of personal bias within the interpretation of the data and decrease its effect on the results (i.e., areas of significant discrepancy were not included in the final results).

Step 7: Looking for patterns across cases. At the completion of Step 6, I laid out each participant's table of superordinate and emergent themes side by side and searched for patterns across cases. This process resulted in relabeling and reconfiguring some of the themes to best demonstrate how each participant represented idiosyncratic occurrences while still sharing higher order qualities. During this point in the process, I determined which emergent and superordinate

themes I would keep, and which I would discard. I took several factors into account while doing so, including (a) prevalence across cases, (b) relevance to topic being studied, and (c) to what extent my personal biases were reflected in the superordinate and emergent themes. With regard to prevalence across cases, I first searched for superordinate and emergent themes that were the same or very similar, that occurred across the majority of cases. This process resulted in a list of common superordinate and emergent themes, as well as the discarding of themes that were only relevant to single cases.

Next, I analyzed the master list of emergent and superordinate themes based on their relevance to my statement of purpose and research question. While scanning the themes, I considered content surrounding participants' histories with AN, in addition to content surrounding their experiences during pregnancy (i.e., transition into pregnancy, body image, relationship with food, relationship with exercise, overall psychological well-being, social support, and experiences with healthcare) to be most relevant.

Throughout the entire process of data analysis, including the last step of compiling and finalizing a master list of emergent and superordinate themes, I referred back to my reflective journal to consider the degree to which my preconceived ideas or biases were impacting my theme selection. For example, as it was my hope going into this study that the results would highlight and expand upon mechanisms behind relapse during pregnancy, as well as provide insight into potential intervention opportunities, I remained cognizant of the fact that I may have been hypersensitive to evidence of symptom resurgence. When evidence of symptom resurgence arose in themes, I was careful to refer back to the verbatim transcript and initial notations to analyze whether the theme was supported with data. Only if I felt that there was enough evidence of the theme within the original transcripts did I include it in the master theme table. At the

conclusion of this step, I created a master chart of superordinate themes and emergent themes (see Appendix D) as well as a chart of superordinate and emergent themes with corresponding quotes from the interview transcripts (see Appendix E).

Quality Assurance

Yardley's four principles. Smith et al. (2009) utilize Lucy Yardley's (2000) four principles to assess the quality of qualitative research. Below, I describe the ways in which I attended to each of these four principles in the present study.

Sensitivity to context. This principle can be understood as the sensitivity to the contextual elements within which a study is situated (e.g., the sociocultural milieu, existing literature on the topic, material obtained from the participants; Smith et al., 2009). The purposive sampling, as well as the general idiographic approach of the present study, demonstrated sensitivity to context from the outset of the research. Additionally, sensitivity to context was demonstrated through the extremely thorough process of data analysis. Furthermore, sensitivity in regard to interpretations was further strengthened through the inclusion of verbatim extracts from the participants. Lastly, sensitivity to context was demonstrated through the substantive literature that was utilized in this study as a tool to both orient the reader to the topic as well as support the findings in the discussion.

Commitment and rigor. Commitment can be understood as the researcher's personal investment in the research process, while rigor can be understood as the thoroughness of the study. In the present study, commitment was demonstrated through the degree of attentiveness to each participant throughout the interview process, with respect given to the participants' level of comfort. The demonstration of commitment was also demonstrated through the care in which data analysis was carried out, and is in many ways synonymous to the purposeful sensitivity paid

to context (Smith et al., 2009). Rigor was demonstrated in the present study through the purposive and appropriate sampling of participants with respect to the research question. Participants were carefully selected in order to create a reasonably homogenous sample to match the phenomena being studied. The analysis conducted in this study was also demonstrative of rigor as I valued, utilized, and interpreted both the idiographic content of individual narratives while also exploring and describing important relationships among themes of the larger group.

Transparency and coherence. This principle can be understood as the level of clarity in describing the research process within the write-up of a study, coherence of the results and argument, and the degree of fit between the research completed and the underlying theoretical assumptions of the approach being implemented (Smith et al., 2009). Transparence was demonstrated in the present study through the careful and thorough description of the research process, description of participant selection, sample of the interview schedule, and breakdown of the steps involved in data analysis. Coherence was demonstrated through the logical presentation of themes, and relationships among data points. Additionally, contradictions within the data were reviewed and discussed. Coherence was also demonstrated through the linear and methodological implementation of IPA, as outlined in scholarly literature.

Impact and importance. This principle can be understood as the degree to which the information being presented within the write-up of a study is interesting, important, or useful (Smith et al., 2009). The importance of the topic of interest in the present study was highlighted by the contextual information from extant literature that described the significant risk associated with symptoms of AN during pregnancy. Additionally, it is described in the present study how the research would fill in some of the gaps that were present within the existing research, thus implying the importance of the current study. Lastly, the degree of impact or usefulness of the

current study was demonstrated through the development of clinical implications and recommendations based on new findings, and the support of existing recommendations based on similar findings in extant literature.

Bracketing of biases. In addition to the use of a secondary coder, I employed self-reflective journaling to further address the impact of researcher bias. Self-reflective journaling is a strategy that facilitates reflectivity. It allowed me to examine and clarify my own personal assumptions, goals, belief systems and subjectivities that came into play throughout the research process (Russell & Kelly, 2002). Throughout the month prior to the initiation of data collection, I assessed my own preconceptions about the subject matter (i.e., pregnancy, eating disorders, AN, exercise, food, motherhood, etc.) and created a transparent list pertaining to my biases. I then engaged in in self-reflective journaling directly before and after conducting each interview, and assessed the possible ways that the interviewer–interviewee interaction may have been impacted by both my own personal biases and alternate sources (e.g., demographics, socioeconomic-status, cultural background, etc.). Throughout the process of interview transcription, data analysis, and theme identification, I regularly referred back to my reflective journal to analyze the degree of impact that these factors may have had on the research process and data analysis. The implementation of the secondary coder was then employed, in part, as an attempt to suspend the impact of these factors on the validity of the research.

Results

Participants

Three women agreed to participate in this study. All three women reported having a history of clinically diagnosed AN, and had become pregnant within the last five years while in remission from the disorder. A description of each participant is presented in the order in which

interviews were conducted. BMI of each participant is not specified due to the limitations of retrospective self-report, however the qualitative label for the severity of each participants AN diagnosis is reported, and was determined through the analysis of demographic data surrounding weight, height, trajectory of AN, and is based on DSM-V criteria. Categorizing of *partial remission* or *full remission* was approximated through the descriptions of the symptoms that remained present during the periods of time being described, and based on DSM-V criteria.

Participant 1. Jennifer was a 26-year-old married, Caucasian female with a bachelor's degree, who was in graduate school working toward her master's degree at the time of the interview. Jennifer gave birth approximately 22 months prior to the interview date. She has had only one pregnancy. The identified pregnancy was unplanned. Jennifer gave birth vaginally. Onset of caloric restriction began at age 14 and gradually worsened over three years. At approximately 17 years old, she began to experience amenorrhea, and was admitted to an eating disorder clinic for 10 weeks to treat the diagnosis of Anorexia Nervosa, Restricting type, Moderate. During this course of treatment, Jennifer began to intermittently purge, and would continue to do so for approximately two years. Jennifer received outpatient psychotherapy for AN following her 10-week treatment at the eating disorder clinic. She achieved partial remission at approximately 21 years old (approximately seven years after onset of symptoms), and conceived her child at 24 years old, while in full remission from the disorder. Her pregnancy was complicated by a number of medical conditions including several urinary tract infections, a septic kidney infection, and polyhydraminos (i.e., an excess of amniotic fluid in the amniotic sac). She did not receive mental health treatment during pregnancy. Specific gestational age at time of delivery was not reported, however Jennifer did report that her baby was delivered vaginally "two weeks early." Respiratory issues, resulting in a 10-day ICU stay, complicated her

newborn's nursery course. No additional psychiatric history was reported.

Participant 2. Kaitlyn was a 29-year-old married, Caucasian female with a master's degree. She gave birth approximately six months prior to the interview date. The identified pregnancy was planned. Kaitlyn gave birth vaginally. She had one prior pregnancy that resulted in miscarriage in the first trimester. In regard to AN, onset of caloric restriction and over-exercise behaviors began at age 24. At age 25, Kaitlyn was formally diagnosed with Anorexia Nervosa, Restricting type, Mild, and engaged in individual and group psychotherapy. Partial remission was achieved approximately three and a half years after the onset of AN symptoms. Kaitlyn became pregnant approximately five months after achieving partial remission. Approximation of full remission was achieved within the first month of pregnancy. Pregnancy course was reportedly uncomplicated with regard to medical conditions, and her infant was delivered vaginally at full term. Kaitlyn continued to engage in mental health treatment in the form of therapy throughout her pregnancy. In addition to AN, psychiatric history was positive for a previous diagnosis of generalized anxiety disorder.

Participant 3. Naomi was a 32-year-old married, Caucasian female with a PhD. She gave birth approximately four months prior to the interview. The identified pregnancy was planned. Naomi gave birth vaginally. She had two pregnancies prior to the identified pregnancy, one of which resulted in a miscarriage, and the other of which resulted in the birth of her first living child, who was approximately three years old at the time of the interview. With regard to AN, onset of caloric restriction and over-exercising occurred at age 15 and continued to worsen over the course of four years. During this period, Naomi experienced amenorrhea. She did not receive a formal diagnosis until age 19, at which point she was diagnosed with Anorexia Nervosa, Restricting Type, Severe. After receiving the diagnosis, she began receiving outpatient

mental health treatment through an integrated treatment team that included therapists, nutritionists, and medical providers. She achieved partial remission halfway through her undergraduate studies (i.e., approximately six years after onset of AN symptomology), which lasted for approximately two years, and occurred while she was receiving mental health treatment. This period of partial remission was followed by a subsequent relapse after entering graduate school and discontinuing treatment. Naomi reinitiated treatment approximately three years into her episode of relapse, and achieved partial remission once more. The identified pregnancy took place approximately two years after having achieved her second partial remission. She did not receive mental health treatment during her pregnancy. Pregnancy course was complicated by her son's restricted growth rate at approximately 32 weeks gestation. Specific gestational age at time of delivery was not reported, however Naomi did report that her baby was delivered vaginally "a little early" but close to term. Delivery and nursery course were reportedly uncomplicated. Additional psychiatric history was denied.

Overview

Interpretative Phenomenological Analysis (IPA) of the three semi-structured interviews resulted in the emergence of seven superordinate themes. Several superordinate themes also encompass emergent themes that arose within the overarching category (see Appendix E). Superordinate themes were as follows:

- *Control* as a Mechanism of AN
- Experiences of Lack of Agency Over Body and Health of Pregnancy
- Rigidity vs. Restriction: Lingering AN Voice and Inflexibility
- Pregnancy Positively Impacts Some Aspects of Relationship with Food and Body Image
- Environmental Stressors Impair Level of Engagement in Self-Care Behaviors

- Social Relationships Have Significant Influence on Formation of Self-Perception and Engagement in Health-Maintenance Behaviors
- History of AN Minimized During Routine Prenatal Medical Care

These superordinate themes were reflected in most of the participants' narratives; however, there were also areas of divergence and difference among their emergent parts. These areas of discrepancy are identified and commented upon below.

It is of importance to note that the themes identified in this study are each just one possible account of the experience of pregnancy among women in remission from anorexia. They do not cover all aspects of the participants' experiences, and were selected due to their commonality among participants' narratives, as well as their relevance to the study. Verbatim extracts from the interview transcripts will be used to illustrate the results. It should be noted that some minor changes have been made in the presentation of these verbatim extracts to improve readability. Minor hesitations, word repetitions, and utterances such as "umm" have been removed in most instances. Missing material is indicated by ellipses, and where information has been added (e.g., to explain to what or to whom a participant is referring), it is presented within square brackets. All identifying information has been removed or changed, and the participants are identified under the pseudonyms of Jennifer, Kaitlyn, and Naomi to protect the anonymity of the participants.

Theme 1: Control as a Mechanism of AN

This superordinate theme addresses participants' accounts of the facilitating factors behind the development and trajectory of their experience with AN. Though the accounts differ in detail, all three participants cited that their disordered eating worsened in the face of life transitions or, similarly, as a tool to cope with distress by regaining control.

Both Jennifer and Naomi attributed specific life transitions to the worsening of pre-established eating disorder symptoms. Jennifer described that her restrictive eating worsened in the wake of moving to her mother's house and initiating high school, stating, "When I moved to my mother's house between eighth grade and ninth grade, I moved for high school, that's kind of when things started going downhill" (Jennifer). Naomi provided two specific examples of life transitions that led to an increase in disordered eating behaviors, as demonstrated in the

following excerpts:

> **Naomi:** Yeah, and it just kept getting worse like … it was when I went to college, when I was on my own … the transition of coping … that's when things got even worse.
>
> **Naomi:** So, when I went to grad school … the stress of grad school started, and I started to not be able to cope well. My coping mechanism was to fall back into disordered eating.

Jennifer and Kaitlyn also identified a need for control as a contributor to their eating disorders. Jennifer described how her initial admission to a mental health clinic for eating disorders prompted an increase in methods to regain control, including purging, increased restriction of food groups, and calorie counting:

> Yeah I just, I, I hadn't really gone there by choice and I felt kind of violated and uncomfortable I think. … and I think you know it's often a control thing for eating disorders. So I think like [pause] I don't know maybe that was just my way of maybe retaking control [laughs]. (Jennifer)

Kaitlyn described how her intrinsic need to be in control was challenged in light of a plethora of life transitions and responsibilities, and became a significant facilitating factor in the development and maintenance of her eating disorder:

> I'm very much like a person that needs to be in control. And I think that that was a huge component of the eating disorder, because, I had so many things on my plate. I had this full-time job, and I had part-time school, and I was getting married. There were just so many things going on. … It was like a lot on my plate and I was like okay, I could control one thing, and that was my food intake. (Kaitlyn)

Theme 2: Experiences of Lack of Agency over Body and Health of Pregnancy

All three participants described experiences of lack of agency or control over aspects of their health, their baby's health, and their pregnancy. Additionally, all three participants utilized language that was suggestive of a disconnection between their "self" and their body, though the disconnection was described as having impacted the psyche of each individual in different ways.

The unpredictable nature of the physiological symptoms associated with pregnancy left Kaitlyn feeling anxious about the health of her baby. For example, she explained how the intermittent frequency of feeling the baby move, as well as the fluctuations in her experiences of morning sickness, caused her significant anxiety about whether or not the baby was healthy. She acknowledged that her pregnancy was medically sound throughout, stating that she had no "rational" reason to worry. She instead attributed her distress to her inability to control the pregnancy:

> So, my pregnancy was a very high-anxiety pregnancy. Medically it was totally fine through and through from day one … but I was extremely, extremely anxious about every single thing that was going on. …, so because I think I felt like so out of control with the pregnancy, like I couldn't control what was going on, all the anxiety was around like the health of the baby [rather than weight or body image]. (Kaitlyn)

Kaitlyn explained that she had known several people who had "refused to let go of" their disordered eating throughout their pregnancies, and, as a result, experienced serious complications and miscarriages. Armed with the knowledge of the dangers of disordered eating during pregnancy, she chose not to engage in the restrictive behaviors that once stood as coping strategies to satisfy her need for control. In the absence of the ability to engage in restriction, her anxiety continued to fester without an outlet for relief. Kaitlyn's distress surrounding the lack of

control that she had over her pregnancy, was also compounded by the fact that she had suffered a prior miscarriage. She described how the past experience manifested into a severe sense of dread and catastrophic thinking surrounding her baby's health:

> [I felt] like something bad was going to happen. Something bad had happened to me the first time, and like something bad was going to happen again. And I think that that was sort of like the root of the anxiety for the whole pregnancy. Like I had already had a loss, so like my body already had failed me once, so like of course it's going to happen again. (Kaitlyn)

Kaitlyn explained that she had initially assumed that her weight and bodily changes would be the primary cause for distress during her pregnancy, and explained that she found it ironic that her anxiety manifested instead around the health of her baby.

Naomi described having experienced a lack of agency over her own health and body during pregnancy, particularly in respect to her inability to gain the recommended pregnancy weight, as demonstrated in the following excerpt:

> I don't gain weight very quickly … but they wanted me to gain even more. I even like met with a nutritionist and I was trying to eat more but I just, I don't know, my body was doing what it was doing. (Naomi)

During her third trimester, Naomi was confronted with the fact that her son was diagnosed with growth restriction. She considered the situation to likely be one of circumstance due to her genetics, however did begin to experience self-doubt in her ability to monitor her eating behaviors and gauge her remission status. She described simultaneously experiencing a sense of helplessness and self-doubt as she struggled to determine her role in the medical complications:

> Because I have a history with anorexia it did complicate things because we're trying to

> tease out what is just genetics and what is like eating behaviors. And so, the growth restriction was hard because, I, I personally was like well, 'am I not doing as well as I think I'm doing?' (Naomi)

Jennifer described experiencing a lack of agency over her body as a result of the medical complications that she experienced throughout it. Jennifer's narrative surrounding her health issues demonstrated both similarities and contrasts to those of Kaitlyn and Naomi. In regard to similarities, Jennifer experienced distress in the face of bodily conditions that she felt were out of her control:

> I mean I think the biggest component [of distress at the end of pregnancy] was the anticipation [of birth], and of course my health. … My immune system was going to crap, everything was starting to get really bad. (Jennifer)

Later, she described how the challenge of regaining control over her medical issues carried into the postpartum period and contributed to what she considered to be a "resurfacing" of anorexia-like behaviors:

> But I think what really started the whole thing in terms of projecting my anorexia symptoms onto [my baby], was just, getting, getting control of the [medical problems]. (Jennifer)

In the excerpt above, Jennifer refers to "projecting" her anorexia symptoms onto her child. This is in reference to her belief that her experience with breastfeeding post birth facilitated a relapse in AN symptomology. In the account below, she explains how the therapist, who she began seeing after giving birth, connected her history with AN to the difficulty of coping with the challenges of breastfeeding:

> [The] way in which you might kind of sort of say there was a resurface wasn't actually with my own behavior or my own eating, it was around breastfeeding. When [the baby] refused to breastfeed, I couldn't just accept that, because breastfeeding was like part of my idea of being a mother. And I think I pushed it for way too hard for way too long. … My therapist kind of is associating that with my own need for control. … like somehow I have projected that onto [the baby]" (Jennifer)

Jennifer's son's refusal to breastfeed challenged her personal idea of motherhood, and was experienced as a lack of agency over her body. Rather than regain control through the restriction of food, she associated her "overdoing it" with breastfeeding attempts as a resurfacing of her disordered feeding behaviors.

Jennifer also experienced a lack of agency over her body when considering the many risk factors for preterm delivery that she described as being imminent and out of her control:

> There were like 5000 different things that should have made me preterm which was, of course, one of the biggest things that worried me throughout the whole pregnancy … There were a million things that should have made him really early. (Jennifer)

A contrast was observed in the ways in which Jennifer reacted to experiencing a lack of agency over her body, when compared to the other participants. Unlike the other participants, Jennifer placed emphasis on the strengths of her body, and indicated that she had a greater level of confidence in its autonomous "choices" when considering the health of her baby. In the following excerpt, she describes feeling positively about the delivery course, and demonstrates having had a degree of trust in its autonomous decision to give birth at the time that it did:

> It's just really lucky that he came out exactly when he did because … if he had been a day earlier he wouldn't have been breathing on his own, if he'd come a day later I would

> have had to be put in surgery to get him out. So like it was perfect…I think the body knows a lot of things. (Jennifer)

Theme 3: Rigidity vs. Restriction: Lingering AN Voice and Inflexibility

This superordinate theme aims to capture the participants' accounts of rigid cognitive and behavioral process present during pregnancy. Though participants described these behaviors as playing a different role than they did prior to remission (i.e., exercising to stay active vs. to lose weight), they attributed some of their inflexibility to residual distortions in the cognitive processes that lingered even after entering into remission. Both Kaitlyn and Naomi are represented in this superordinate theme.

Rigidity surrounding diet and health. The narratives of both Kaitlyn and Naomi were demonstrative of very rigid cognitive patterns and behaviors when it came to dietary guidelines throughout pregnancy. Kaitlyn's rigidity was a result of her concrete beliefs surrounding prenatal nutritional safety:

> I was definitely very anxious or very cautious about my food intake when it came to, again, safety of the baby. Like checking that, 'this is pasteurized and this is cooked enough'—there was a lot of anxiety around that. It wasn't so much like 'I can't eat a bagel or I can't have this donut,' or whatever, it was just much more like, 'is this fish or chicken cooked enough?' 'Is this egg boiled enough?' That kind of thing. (Kaitlyn)

Kaitlyn's rigid adherence to dietary safety was so restrictive that her therapist considered it to be disordered, however, Kaitlyn did not agree with this assessment. Instead, she felt that her therapist's views on prenatal nutrition were inaccurate:

> I mean if you asked my therapist she would tell you that I still had an eating disorder while I was pregnant, only because I was so, I was restrictive in a way that was ensuring

> the safety of the baby. So, I wasn't eating foods that had any chance of having anything unsafe for the baby. Whereas my therapist told me that she would eat like deli turkey sandwiches like daily, and I was like, 'you're insane.' (Kaitlyn)

Kaitlyn's adherence to strict health and safety guidelines appeared to have served as a coping mechanism to regain some level of control over her baby's health, and the anxiety that arose from her lack of agency over pregnancy itself.

Similar to Kaitlyn, Naomi adhered to strict dietary guidelines based on her personal beliefs surrounding health, however these beliefs were present prior to pregnancy and were not specific to prenatal safety:

> The other thing that I really struggle with is I'm really concerned about healthy eating, and so probably one of my biggest struggles is, you know, indulging and things that may not be considered the most healthy thing to eat. (Naomi)

Naomi's hyper-focus on healthful eating was also present during her pursuit to gain the recommended pregnancy weight:

> I was actually okay with gaining weight but I was like 'the foods that I'm eating better be healthy' and I wouldn't let myself eat anything that was… I would struggle and feel guilty if… I would eat something that was not as healthy. (Naomi)

In the previous quote, Naomi's language is suggestive of a fluctuation in her perception of the presence or absence of restrictive behaviors when describing her focus on health (e.g., "I wouldn't let myself" vs. "I would struggle and feel guilty if"). In contrast to Kaitlyn, Naomi described there being a connection between her history of AN and her rigidity surrounding health foods during pregnancy, as demonstrated in the following excerpt:

> If I eat like an unhealthy thing occasionally it's really probably not going to impact the baby, but with the eating disorder part of the brain, it doesn't allow you that leeway to be like, 'okay every now and then this is okay.' so, just like eating it once or twice you know there, there's that kind of guilt or that kind of worry about like 'oh this is really unhealthy is it going to hurt me or hurt the baby's health and stuff like that. (Naomi)

In addition to expressing her concern surrounding healthful eating, Naomi described herself as being a highly rigid person when it comes to the quantity and variety of foods that she consumes. Like her inflexibility surrounding health foods, these areas of rigidity also carried over into pregnancy. Naomi found it difficult to break out of her rigid dietary patterns when she met with a nutritionist following her son's diagnosis of growth restriction:

> I'm very rigid, let's put it that way, like I try to eat certain types of food, and I eat them like at certain times, and I don't like when I feel like I have to eat more. It's the hardest thing for me, with going to a nutritionist, having to get out of that rigidity. Like adding foods that I eat or adding in like textured snacks and extra food items that are not part of my normal, like my normal eating pattern. (Naomi)

Due to her difficulty breaking out of her rigid routines, she described having ultimately only adhered partially to the recommendations from the nutritionist.

Avoidance of the use of the word *restriction*. This emergent theme was seen in both Kaitlyn and Naomi's narratives. Throughout their interviews, participants explicitly identified their eating behaviors as having characteristics of restriction, but hesitated to use the word due to the function of the behavior. For example, though Kaitlyn explained that her therapist considered her eating to have been restrictive during pregnancy, she, herself considered her eating habits as rational and in the service of keeping her child safe from harm. When discussing her strict

adherence to nutritional guidelines, she stated, “I don’t call it restricting because it’s a known thing [to not eat specific foods when you’re pregnant]. To me that wasn’t restricting, but I was definitely like overly cautious,” (Kaitlyn). Naomi also hesitated to use the word restriction, despite the fact that she struggled to consistently add the recommended calories to her diet during pregnancy. This is demonstrated in the following excerpt:

> I’m really good at eating a very set amount of food, but when I have to eat more I’m not. That’s what’s hard, it’s the increased calories, I wasn’t as restricting [as prior to remission], I was just, like, sometimes not eating more. (Naomi)

Naomi explained that her dietary rigidity existed in the absence of a fear of weight gain, positioning it instead as being related to a combination of innate personality traits and lingering AN cognitions.

Continuation of rigid patterns surrounding exercise. This emergent theme was also present in the narratives of both Kaitlyn and Naomi. Both participants described having a regimented workout schedule prior to conception that carried over into their pregnancy, and that they considered at times to be reminiscent of their exercise habits prior to remission from AN. In contrast to these two participants, Jennifer described having a less regimented exercise routine prior to pregnancy, and discontinuing exercise all together once she became pregnant.

In the excerpts below, both Kaitlyn and Naomi describe how they attempted to keep their regimented exercise schedule throughout pregnancy, until the physical limitations forced them to modify or discontinue their behaviors:

> **Kaitlyn:** So, I think that, that [her exercise habits prior to pregnancy] was the one thing that sort of remained constant. While I got pregnant, I wasn’t exercising to lose weight, but I was anal about going to the gym. Like I had to go five days a week, six days a week,

> whatever it was. … And I stopped going to the gym at 38 weeks because I was just like 'I'm so enormous and I cannot do this anymore.'
>
> **Naomi:** I exercised throughout the pregnancy … I ran for as long as I could and then eventually I would get too big and uncomfortable so then I have to walk instead. … Before I got pregnant, I would run almost every day … and the first few months of pregnancy I kept doing the same thing as long as I could with my energy level. But some days I just like wouldn't. With pregnancy, the first trimester, you're very tired and I do remember one day feeling so tired that I just couldn't, I just couldn't run and I didn't. I just couldn't. It was probably midway through, over the course of pregnancy, what I started doing was running fewer days of the week so I would run a little bit like three or four days of the week.

In the accounts above, both participants use language indicative of a lack of agency over their exercise behaviors. For example, Kaitlyn described that she "had" to go to the gym for a set amount of days a week, rather than saying that she "chose to." Additionally, she stated that she stopped going to the gym only when her bodily changes became so great that she could not continue. Naomi's experience of a lack of agency over her exercise habits is most prevalent in her description of forced modifications. The manner in which she recalls one very specific time that she "couldn't" run during the first trimester, and her emphasis on the limitation while reflecting on the memory, suggests that this modification was an outlier. Naomi also described how having to modify her exercise regimen due to the physical limitations of pregnancy negatively impacting her mood.

Both participants reported that their exercise habits during pregnancy were reflective of AN behaviors that had continued to linger post remission. For example, while Kaitlyn's view of

the role of exercise changed during pregnancy, her rigidity in the frequency and prioritizing of it was reminiscent to her disordered behaviors prior to and post remission from AN:

> I definitely didn't force myself to go in the way I once did, but I definitely was adamant about going and made it a part of my day. I guess that, even though I viewed it a little bit differently, I just viewed it as being active versus like 'let's lose weight'—I definitely was very diligent about going. So, I guess in a way that's sort of carried over with me into the pregnancy. (Kaitlyn)

Similarly, Naomi demonstrated insight into how her difficulty modifying rigid behavioral patterns of exercise could be deemed "unhealthy":

> I think that there are times that my relationship with exercise, … even when I'm pregnant, can be unhealthy because there comes a point in pregnancy where I would have to … modify things, and I have a really hard time doing that. Like slowing down and being like 'ok, you just need to walk instead of run' … I know cognitively when I'm pregnant that, that it's a time to not overdo it. … but I would still have to work through some of those tendencies to exercise hard. (Naomi)

In the account above, Naomi's present-tense language, and use of the word "unhealthy," indicates that her view of the nature of her exercise behaviors is wavering in regard to whether it is disordered nor non-disordered. Similar to the cognitive distortions that she identified in her thought processes surrounding the consumption of unhealthy foods (see "Rigidity surrounding diet and health*"* section*),* she struggled with the dichotomy between her conscious awareness of the need to modify her exercise, and her pre-existing, rigid patterns that pulled her to over-exercise.

In contrast to Kaitlyn and Naomi, Jennifer's description of her relationship with exercise prior to pregnancy suggested that it was of lesser significance in her life. This is demonstrated in the following account, where Jennifer describes how she was influenced by her husband to start exercising later in life:

> When I met my husband, he was really an exercise fitness buff and I think I kind of took a note from his book and had actually started running for the first time in my life, and I was, you know, doing pushups before bed and stuff. I was getting pretty good about maintaining good physical health. But of course, once life got crazy with the pregnancy, it kind of went out the window. (Jennifer)

She went on to explain that once she became pregnant she discontinued exercising. Without evidence of remorse, she described "life" itself as being exercise enough during pregnancy.

Theme 4: Pregnancy Positively Impacts Some Aspects of Relationship With Food and Body Image

All three participants are represented in this superordinate theme. Though they were different in detail, each narrative account demonstrated some ways in which pregnancy, itself, positively changed participants' relationship with food, and enabled them to maintain a generally positive body image in the face of undesired changes. Kaitlyn and Naomi's experiences both included an increase in flexibility with some aspects of their diet. This shift in relation to diet did not arise in this way throughout Jennifer's narrative, however this is understood to be due to the fact that her relationship with food was significantly less rigid than Kaitlyn and Naomi's in the months prior to pregnancy. Jennifer did say, however, that she had a larger appetite during pregnancy, and did not indicate experiencing difficulty appeasing it.

In perhaps the starkest example of a change in relation to diet during pregnancy, Kaitlyn reported experiencing an increased sense of freedom surrounding foods that were once off limits to her when trying to control her weight. Despite her rigidity surrounding foods that were "safe" for the baby, she did not display rigidity or restriction with respect to the quantity or variety of foods that she consumed. She found this new flexibility in her diet to be in stark contrast to the rigidity that was present prior to remission from AN, stating, "I really ate so many bagels and so many French fries when I was pregnant which was like something that I never even thought imaginable when I had an eating disorder" (Kaitlyn).

When asked to describe the most enjoyable parts of pregnancy, Kaitlyn stated, "Ironically, eating whatever I wanted," (Kaitlyn). The universal expectation of weight gain during pregnancy granted her permission to indulge in foods that she previously restricted. For example, she regularly craved and consumed cream cheese throughout her pregnancy, whereas prior to pregnancy she would not allow herself to eat it. In the following account, she explains how this new sense of freedom outweighed the bodily changes that took place:

> I didn't mind having a belly, which is so bizarre because of the eating disorder. So I just, I didn't mind having this belly. ... I was just like—you know what? I'm pregnant and I eat bagels and cream cheese literally every day and it's awesome. It's what I'd been missing out on all these years when I was like so miserable and skinny. (Kaitlyn)

Whereas Kaitlyn described her ambivalence toward weight gain as facilitating increased freedom with her diet, Naomi identified the health of her baby as having been the facilitating factor underlying her shift in her relationship with food. She described how sustaining another life gave her newfound motivation to eat adequately, stating, "when I'm just hurting myself, I have less motivation to change I guess," (Naomi). Though the dietary demands of pregnancy

sometimes triggered cognitive distortions associated with AN, considering her child's health made it easier for her to rationalize an increase in her caloric intake:

> When I'm pregnant it's easier for me to logically think through 'well it's okay to eat this because my body needs it' like I'm growing another child and so like … I need energy, I need to eat in order to benefit the health of this child … being pregnant was like, another motivation to eat adequately, when [I'm] sustaining another life. (Naomi)

Though Naomi struggled to introduce new textures and food groups into her diet during pregnancy, she did describe a slight increase in the variety of foods that she consumed. In the following account, she explains how she craved and consumed food items that were limited in her diet prior to pregnancy:

> I don't really love eating meat. I do eat it sometimes, it's just not my preference, I'm more of a vegetarian type, but when I was pregnant I wanted to eat meat, and a lot more of higher fat higher protein foods, which I did. I just really enjoyed them and wanted them. (Naomi)

Pregnancy also had a positive impact on aspects of participants' body image and acceptance. Though participants reported having felt, at times, negatively about their bodies during pregnancy, all three described having maintained a generally neutral or positive body image throughout their experience. Pregnancy, itself, helped participants to more readily justify and accept the less desirable bodily changes that they were faced with. The temporary nature of pregnancy brought Kaitlyn and Naomi relief in the face of weight gain. Jennifer found that, though she experienced some dissatisfaction with her body, it was counterbalanced by the simultaneous appreciation that she felt toward its ability to carry a child. The following excerpts demonstrate examples of how pregnancy positively impacted participants' ability to accept

bodily changes:

> **Kaitlyn:** I definitely gained a significant amount of weight umm but I also didn't really care. I was just like 'I'll just deal with it later,' and like that was my mentality the whole time
>
> **Naomi:** My body goes back to mostly normal really quickly so I knew the second time around that once I had the baby—I would not feel [negative about my body]. … I felt like kind of self-conscious, but, I don't know, it didn't really bother me. Like I was very able to [tell myself] 'There's nothing I can do about this. That was just the way it is and the way it was going to be, and it will go away once the baby is born.' (Naomi)
>
> **Jennifer:** I mean there was definitely some self-esteem stuff going on. I didn't feel great about how I looked; But there was also a component of being you know happy that my body could actually do something as amazing as creating a child you know? (Jennifer)

Theme 5: Environmental Stressors Impair Level of Engagement in Self-Care Behaviors

Two out of the three participants described how environmental stressors overshadowed their pregnancy experience as a whole, and had an impact on their ability to engage in self-care behaviors. This emergent theme did not present itself in Kaitlyn's narrative with regard to her identified pregnancy, however a similar theme was seen in her description of life changes and responsibilities that facilitated the onset of her eating disorder, as captured in the superordinate theme "Control as a mechanism of AN."

Jennifer and Naomi both described how the gestalt of their pregnancy experience was characterized by the responsibilities the demands of significant external stressors. Jennifer's pregnancy was unplanned, and she initially felt unprepared to have a baby. Her pregnancy experience was entwined with making alterations to her environment and lifestyle in order to

prepare for the arrival of a baby. The following account demonstrates how the planning and preparation that took place was chaotic, and consumed much of her emotional energy and attention:

> [Becoming pregnant] was really exciting but crazy I mean it all kind of just, it's just a blur to be honest, it was just a blur of activity. … I just had a lot of stress, you know, and worrying about the environment that I was bringing [the baby] into. … but you know it's just, trying to get everything to come together, it was crazy. You know, we weren't ready yet, so making it happen was definitely the hardest part of pregnancy. (Jennifer)

In addition to working three jobs, two of which she acquired during her pregnancy, Jennifer was also planning a wedding, and searching for a new home to move her family into. She described how her attention to these environmental stressors took a toll on her physical health, and ultimately caused her to neglect to treat a kidney infection that later went septic. She stated, "[the third job] kind of pushed me beyond my limits with my kidney infection, and everything that I had been ignoring too long."

Similarly to Jennifer, Naomi's energy and attention was consumed by external factors that ultimately overshadowed her pregnancy experience. Her mother-in-law tragically passed away just weeks prior to the conception of her child, and much of her pregnancy was spent coping with the loss both emotionally and pragmatically, as described in the following excerpt:

> It was actually a somewhat stressful pregnancy because about two weeks before I conceived and became pregnant my mother in law died suddenly. … I spent much of the time that I was pregnant working through the loss. … and we had to clean out her entire house sell it and stuff like that. … so, a lot of my pregnancy was not even really thinking about the baby, I know that sounds terrible. (Naomi)

Naomi was also caring for her two-year-old child at the time of her pregnancy, which required much of her time and energy. Throughout her narrative, she used language that indicated that she was operating on survival mode, leaving the pregnancy itself to be somewhat of a background factor:

> A lot of it was just focused on just getting done what we needed to do … it was just a lot of life changes. … I didn't really think about the pregnancy that much … the baby growing was just something that was just happening. (Naomi)

Pragmatically, Naomi's ability to engage in medical care was impacted by external demands. Specifically, she and her family moved out of state, which resulted in a lapse of two months without seeing a medical provider. Similar to Jennifer, Naomi acknowledged that addressing these external factors impacted her ability to care for her health:

> I did have a harder time keeping myself rested and fueled because we had so much life change happening. I don't think I took as good care of myself as I should have, but yeah, life happened. (Naomi)

Theme 6: Social Relationships Have Significant Influence on Formation of Self-Perception and Engagement in Health-Maintenance Behaviors

This superordinate theme aims to capture the significant influence that social relationships played in each participant's narrative. Social relationships positively and negatively impacted body image, as well as influenced engagement in positive self-care behaviors.

Satisfaction of body strongly influenced by positive and negative feedback. All three participants are represented in this emergent theme. Each participant described fluctuations in their satisfaction with their body in response to comments made by others about weight and appearance.

Jennifer and Kaitlyn described experiencing a decrease in their self-esteem in response to comments made by external sources about their weight and size. Jennifer described how working in a public facility during her third trimester left her vulnerable to a lot of comments about her body, stating, "I got comments up the wazoo, [they'd say] 'You sure you're not having twins? You look like you're ready to pop' like every five seconds" (Jennifer). Though she mainly felt annoyed by these comments, she also described them as compounding her already fluctuating self-esteem.

Kaitlyn described moments of bodily dissatisfaction as having been driven primarily by external comments rather than manifested by intrinsic discontent. She described how female family members made hurtful comments about her weight gain both to her face and behind her back, so much so that she felt compelled to reassure her family that she would lose the weight after giving birth:

> When [my family members] would make comments to me [about my weight], … I'd be like 'ok like I'll deal with whatever weight issue you all think that I have after I'm done being pregnant' … So at those times I would feel very uncomfortable. (Kaitlyn)

She went on to attribute some of the judgment from her family members as stemming from their own history of "eating issues."

In a similar fashion as to how negative comments were described as facilitating increase body dissatisfaction, Kaitlyn and Naomi described how affirmative comments from their spouses positively impacted their self-image. Below, excerpts from Kaitlyn and Naomi provide examples of the helpful statements that their husbands made to them:

Kaitlyn: [My husband] would always reassure me … like that like I'm beautiful, and I'm pregnant, and I'm beautiful at all sizes, and all that really nice stuff. So he was definitely my number one [support].

Naomi: My husband was really good about telling me that he enjoyed seeing me pregnant. … When I saw the other women my size, I think they're really cute … and to have my husband reinforce that that's how I looked and that it was cute. … It was just that positive reinforcement [that helped].

Desire for prominent pregnancy features. Another demonstration of the influence of external perception on participants' body image arose in the emphasis that they placed on having prominent pregnancy features. Jennifer described how the most difficult stage of pregnancy for her, with regard to body satisfaction, was the period during which she was beginning to gain weight, but did not yet have the features that made it explicit to others that she was pregnant, rather than just "fat":

Oh well of course in like the second trimester especially—that's kind of when you start just looking quote unquote fat, but it's not necessarily clear that you're pregnant yet—that was the toughest phase to deal with. When it was just like 'I just look fat, I don't look pregnant.' (Jennifer)

Jennifer went on to describe how her distress at this time was ultimately manageable due to the fact that most of the people that she surrounded herself with knew that she was pregnant.

Naomi too placed emphasis on the positive associations of a prominent baby bump. She described how it was "helpful" in regard to her body satisfaction. In the following account, she describes how she positively viewed the physical appearance of other women who were similar to her in size, and because of that, felt reassured that she looked good as well:

> When I saw the other women my size—I think they're really cute because they're like, they're tiny and then there's this cute ball in the front, instead of just being like a blimp you know so it was actually helpful to have [the baby bump] (Naomi)

Naomi's use of the word "blimp" to describe a body that has undergone weight gain but not a prominent baby bump, highlights an aversion to "fatness" similar to the one demonstrated through Jennifer's account of her appearance being "fat but not pregnant" during the second trimester. Similarly, Kaitlyn's desire for a "baby bump" also highlighted the positive association to explicit indicators of pregnancy:

> I was excited to like have this like big belly and whatever, Like I was like so excited about that. And it's funny because in the end like my belly wasn't so big, … so I was like oh ok my belly is like not so big but like everything else is big. (Kaitlyn)

Spouse plays important role in monitoring and engaging in health-maintenance behaviors. When asked about social support during pregnancy, all three participants identified their spouse as having been their greatest source of emotional support. Jennifer stated, "[Social support] is one thing I had going for me. I mean of course [my husband] was very supportive, he's of course the biggest source of support," (Jennifer). In addition to having provided emotional support, Kaitlyn and Naomi described how their husbands played a significant role in helping to monitor and manage their behaviors surrounding food and exercise:

> **Kaitlyn:** He was always like making sure that I was eating, like just because of my history. He would always just sort of like check and be like 'what did you have for lunch today?' Or if I like wasn't hungry for dinner, he'd be like 'well we have to eat something' like that kind of thing.

> **Naomi:** Okay umm so my husband was my biggest support person for sure, he's very like, he's very good about encouraging me to eat well and to exercise moderately … he's really good about working through a lot of the eating and exercise and even body image things. Biggest support person emotionally and mentally.

Theme 7: History of AN Minimized During Routine Prenatal Medical Care

This superordinate theme aims to capture the participants' experiences with routine medical care during their pregnancy, and the absence or minimization of attention paid to their history of AN. All three participants are represented throughout this superordinate theme, though their presence in each emergent theme is varied.

Minimization or absence of the role of mental health providers. All three participants are represented in this emergent theme, as each described either the absence or minimization of the role of mental health care providers during pregnancy. Neither Jennifer nor Naomi engaged in any form of mental health treatment while pregnant. In contrast, Kaitlyn did continue to see a therapist throughout her pregnancy, however, her therapist's advice surrounding nutritional guidelines appeared to have minimal impact. For example, when asked whether or not her therapist gave her nutritional advice, Kaitlyn responded by stating, "Not in a very specific way. It was more like you need to nourish your baby… blah blah blah." Additionally, though her therapist recommended that she see a nutritionist throughout her pregnancy, she chose not do so, as she found her prior experience with one unhelpful. As discussed in the superordinate theme "Rigidity vs. Restriction: Lingering AN voice and inflexibility during pregnancy," Kaitlyn ultimately felt as though her therapists' beliefs surrounding nutritional guidelines during pregnancy were incorrect, and found them to be in stark contrast to own beliefs about what is and is not safe to consume.

Mental health and emotional well-being are addressed in reactive vs. proactive manner. All three participants disclosed their history of AN to their obstetricians prior to, or at the onset of their pregnancy. Jennifer and Kaitlyn reported having disclosed their history spontaneously, while Naomi reported that her history was disclosed through the medical history paperwork that she filled out at the onset of her pregnancy:

> **Jennifer:** I think I did bring it up with my OB in the very beginning, just because I was concerned about whether or not that might affect the pregnancy.
>
> **Kaitlyn:** Yeah, I think it was my first intake with him when I first met him. … When he was sort of telling me about [ovulation] I was like, oh, 'you know I had an eating disorder,' like I sort of brought it up. It was a point that I felt he should know.
>
> **Naomi:** Umm yeah, I must have disclosed that like at the very beginning when I was filling out the health history.

Jennifer and Kaitlyn reported that their history of AN was not followed-up on again by their obstetrician during pregnancy, and attributed this to their lack of symptomology and steady weight gain, as demonstrated in the following excerpts:

> **Jennifer:** No, I mean I think not many people in my life even knew about it. I mean the medical people and my husband knew about it but, you know I wasn't having any symptoms there wasn't really, there wasn't really much reason for people to worry.
>
> **Kaitlyn:** Even though I was fine considering … my pregnancy and my weight gain, even though everything was fine, [my obstetrician] never checked in on it or asked about it.

Naomi reported that her history with AN was only brought up by her obstetrician in reaction to her son's restricted growth rate, which occurred during the last month of her pregnancy. She stated, "No one ever really [discussed my history of AN] until there was a complication with the

baby at the very like the last month," (Naomi). Similarly, Kaitlyn's obstetrician did not address her pervasive anxiety until the end of her pregnancy. The excerpt below demonstrates how Kaitlyn's obstetrician approached treatment options for her anxiety when she was 37 weeks pregnant:

> My OB recommended when I was 37 weeks that I go on an anti-anxiety medication because I was super-duper anxious … and he sort of wanted to nip that in the bud. … I was very against that because I didn't want to take any medication while I was pregnant because I was anxious about it. So I ended up not doing that while I was pregnant. But he did, he did recommend that very strongly. (Kaitlyn)

Desire for more monitoring and exploration of emotional well-being by medical providers. While Kaitlyn felt that the lack of attention paid to her history of AN did not have an adverse effect on her health or pregnancy, she felt as if further exploration and monitoring of her emotional well-being would have been a positive addition to her care:

> I feel like … the [obstetrician] could have like asked me 'are you feeling ok with the food?' Even not necessarily like at every appointment, but once in a while—could of checked in on that. (Kaitlyn)

Furthermore, she acknowledged that some women who have a history of AN are triggered by different aspects of pregnancy, and as such believes that obstetricians should be more persistent in their monitoring of emotional well-being and health-maintenance behaviors:

> I definitely think that there are people who are pregnant or trying to get pregnant, who had eating disorders or have eating disorders, that are triggered by some part of the process of being pregnant … and it just like definitely could be like checked in on more. (Kaitlyn)

Naomi experienced a lack of emotional support and minimal exploration into potential underlying factors when feeling pressured to gain weight by her medical team. She described how their over-focus on the number on the scale led them to overlook the factors that may have been contributing to her lack of weight gain (i.e., genetics, emotional well-being, etc.):

> I got a lot of pressure to gain a certain amount of weight that was not necessarily realistic for me. Doctors often gave me a hard time [about gaining weight] without really exploring 'how are you really doing?', like 'are you doing really well?' … There was a lot of focus just on weight gain versus like actually like exploring, you know, deeper. (Naomi)

In light of her experience, Naomi described feeling as if medical doctors should further explore the emotional well-being of patients who have a history of AN, as well as offer to provide support, stating, "I think that doctors should explore though, if there is a person that has a history of an eating disorder, and be like, 'What do you need? Do you need anything?' (Naomi).

Discussion

This study examined three women's experiences of pregnancy while in remission from AN. In this section, the meaning of the findings is explored and expanded upon in the context of extant literature. Individual highlights and deviations throughout the interviews are explored. In addition, implications for clinical work, limitations of the study, and suggestions for future research are considered and I describe my final thoughts in light of the completed study.

Researcher's Relationship to the Topic of Interest

Throughout the research process, I took several measures to decrease the risk that my personal biases, assumptions, and beliefs would interfere with the data collection and analysis process. However, given the double-hermeneutic process that occurs in IPA, it is important that I

outline the content of my personal experiences and views as they relate to the topic in order to be transparent about the lens through which I analyzed these data. It is important that the reader keep my relationship to the topic of interest in mind when considering the results.

In regard to my own personal experiences, I perceive the culture within which I live to be one that idealizes thinness and promotes unhealthy methods of weight loss. I, personally, have struggled with my own body image, and have found fluctuations in weight to be trying during moments where I am caught up in the whirlwind of propaganda that equates thinness to self-worth. With regard to pregnancy, I have not experienced it myself, but do wonder whether the impending bodily changes would take an emotional toll on me. I feel that the same cultural idealization of thinness remains present in the portrayal of pregnancy, and have been concerned about the degree of emphasis that is placed on losing pregnancy weight in the media.

With regard to the diagnosis of AN, I have close relationships with women who are currently suffering, or have suffered in the past, from the disorder. Additionally, I have worked therapeutically with several women with this disorder during my clinical training placements throughout graduate school. I have witnessed women in partial and full remission continue to experience, to a lesser degree, some of the same cognitions and fears surrounding food and body image that they felt when their disorder was full-blown and active. At times, I've witnessed some of these women struggle to determine whether their thoughts and behaviors post remission were residual AN tendencies, or just evidence of engagement in socially acceptable human behavior (e.g., eating more vegetables than carbs because that is what is recommended vs. because they know it will keep their weight down).

I did not have a particular hypothesis when approaching this research, as I perceive the experiences of AN and pregnancy to be complex, unique, and sensitive to environmental

influence. My hope for this research was to gain a better understanding of the interplay between the complexities of these experiences, to aid in the identification of the discrete factors that impact the ways in which the experiences take form.

Agreements and Disagreements Between Coders

Utilizing a secondary coder was essential to strengthening the dependability and credibility of this study. Though there were minor differences in the wording or title of the superordinate and emergent themes, there was consensus in the majority of the findings between the secondary coder and myself. Where there was discrepancy between findings, a substantial discussion was held that included a review of my own biases (i.e., located in my reflective journal), and a review of commonalities and differences in our interpretations of the excerpts within the themes. Then, I revisited the excerpts while making a conscious attempt to suspend the biases that I identified as possibly having had influence on the discrepant results.

For example, I identified a superordinate theme called "Renaming and reframing as a form of denial," which included emergent themes surrounding participants' use of hedging language and varying levels of insight when discussing their eating and exercise habits that appeared characteristic of AN during pregnancy. The secondary coder also identified similar emergent themes in two out of three of the transcripts, however, ultimately did not include them in her final compilation of superordinate themes. When discussing this discrepancy with the coder, she explained that, though she interpreted the excerpts similarly, she was uncomfortable making an assumption that the emergent themes were suggestive of *denial* as she had limited knowledge about the role of denial in AN. I then referred to my reflective journal wherein I had listed "denial in AN" and "AN behaviors can come in disguise" as biases that may have influenced my interpretation of these excerpts. It became clear that my prior research and knowledge of the role

of *denial* in disordered eating, as well as my clinical experiences working with women in remission from AN, made me more comfortable identifying *denial* as a likely component in the participants' experiences.

After identifying these biases as potentially having significant influence on my findings within this superordinate theme, I carefully revisited the excerpts in the original transcripts included within the theme. When revisiting the transcripts, I circled back to my reflective journaling and made a conscious effort to compartmentalize the bias in question. For example, when revisiting the excerpts included in the superordinate theme *Renaming and reframing as a form of denial*, I attempted to read the data with a heightened awareness as to how my clinical experiences of denial and AN may have influenced my interpretation. In doing so, I was able to contextualize the behaviors in a way that was less assumptive and more embedded within the data set, while still capturing the essence of participants' tendencies to rename, reframe, or avoid reporting behaviors that were characteristic of AN. This contextualization resulted in two emergent themes that the secondary coder and I agreed fit within the pre-existing and mutually agreed upon superordinate theme of "Rigidity vs. Restriction: Lingering AN Voice and Inflexibility."

The Findings in Brief

Experience of anorexia prior to pregnancy. In the process of analysis, one superordinate theme relating to the experience of anorexia prior to pregnancy arose. Participants identified the concept of control as playing a role in the development and maintenance of their eating disorder.

Experience of pregnancy. In the process of analysis, six superordinate themes relating to the experience of pregnancy arose, as did a number of embedded emergent themes.

Superordinate themes are as follows: (a) Participants described feeling a lack of agency over the physical aspects of their pregnancy, including that of their own health, and the health of the baby; (b) Participants reported the presence of rigid cognitive and behavioral patterns throughout pregnancy, several of which were described as lingering from their history of AN; (c) Participants described ways in which pregnancy positively impacted their relationship with food and acceptance of bodily changes; (d) Participants described how external factors taking place during their pregnancy impaired their ability to engage in self-care behaviors; and (e) Participants described how feedback from others, and others' perception of weight gain, impacted their body satisfaction. Additionally, participants reported how their spouse played an important role in monitoring and engaging in self-care behaviors. Participants described their experience with their obstetricians as lacking in attention to their history of AN, and over-focusing on weight. Participants also expressed a desire for more monitoring of their emotional well-being by their obstetricians.

Exploration, Clinical Implications, and Recommendations

Control as a mechanism of AN. The results of this study demonstrated that the concept of *control* played a prominent role in the development and maintenance of AN for each participant. This basic finding is consistent with previous research that has been done surrounding the theoretical etiology of disordered eating symptoms (Arkell & Robinson, 2008; Button & Warren, 2001; Grisham et al., 2016; Shaffer et al., 2008). Life transitions and periods of high stress were demonstrated as exacerbating the symptoms of AN for participants prior to remission, thus supporting the argument that AN behaviors serve to provide sufferers with an outlet of perceived control amidst external disarray wherein their autonomy is minimized. The homogeneity in regard to participants' understanding of their disorder in relation to the notion of

control, serves as a guiding source in the following exploration of superordinate and emergent themes.

Experiences of a lack of agency over body and health of pregnancy. Consistent with the findings of Fogarty et al. (2018), participants in the present study described how their experience with pregnancy caused them to question their own autonomy and level of control. The common thread among participants' narratives in this superordinate theme revolved around that of their body, and the overall health of their pregnancy. Research has demonstrated that those who suffer from AN often experience a profound disconnection from their body and emotions (Skårderud, 2007). Participants in the present study spoke about their bodies as if they were separate entities to their overall selves, with minds of their own. They experienced their bodies as being predisposed to produce positive or negative outcomes, with varying levels of agency over the health of the pregnancy. The reliance on their body to self-determine whether it would succeed or fail positioned participants in a role of disempowerment, and created distress and anxiety.

Important differences were observed among participants' responses to this lack of agency over their pregnancy. For Kaitlyn, a miscarriage that occurred within close proximity to the conception of the explored pregnancy left her mistrustful of her body. Her inability to explicitly control the outcome of her pregnancy resulted in significant anxiety and hypervigilance to the fluctuations in the physiological pregnancy symptoms that she experienced. In response to this anxiety, she maintained rigid adherence to a concrete set of prenatal nutritional guidelines that involved vehemently restricting foods that she believed to be dangerous. Ultimately, Kaitlyn utilized food as a means to regain a sense of control over the health of her child, in light of the overall powerlessness that she felt over the outcome of her

pregnancy, and mistrust in her body.

Kaitlyn's experience in the present study demonstrates the interplay of the emotional impact of miscarriage and the well-researched tenets of AN (i.e., rigidity, restriction as method of control, concrete thinking, loss of bodily autonomy). This finding suggests that women with a history of AN who have experienced a miscarriage may be at high risk for the development of compensatory behaviors to regain a sense of control over the health of their developing child. Prenatal healthcare providers should be vigilant in assessing the emotional well-being, and levels of anxiety, among women who fit this profile. Given that women with a history of AN are at higher risk of miscarriage when compared to the general population (Fogarty et al., 2018; Shaffer et al., 2008; Tierney et al., 2011), further research should explore the experience of pregnancy among women with a history of AN whom become pregnant after having experienced a miscarriage.

Naomi also reported having experienced a miscarriage prior to the identified pregnancy, however, unlike Kaitlyn, she did not develop compensatory behaviors that were targeted at regaining a sense of control over the health of her developing child. This difference may be due in part to the discrepancies in Kaitlyn and Naomi's pregnancy histories. Specifically, Kaitlyn's only prior experience of pregnancy was one that resulted in miscarriage, whereas Naomi had experienced giving birth to a healthy baby following her miscarriage. As such, Naomi may have had a higher degree of confidence in her body's ability to carry a healthy child when compared to Kaitlyn, thus offsetting the development of compensatory eating behaviors that would serve to control her baby's health. This finding suggests that pregnant women with a history of AN may be less likely to develop compensatory eating behaviors that center around maintaining the health of their baby if they have previously experienced a healthy pregnancy. Future research

should be conducted on the impact of prior pregnancy experiences among pregnant women with a history of AN.

Similar to Kaitlyn, Naomi reported having experienced a lack of agency over her body and the health of her pregnancy. Unlike Kaitlyn, however, Naomi resigned to the notion that bodily autonomy was not possible due to her genetics. Her reliance on external factors to explain her challenges with weight-gain and caloric consumption appeared to facilitate a degree of denial surrounding the disordered nature of her eating habits. Her identity as a "genetically small person" positioned her as disempowered in the pursuit to gain weight during pregnancy, as her locus of control was greatly external. Her narrative suggested that she felt powerless to her body's autonomous decisions, and her external locus of control appeared to limit her active engagement in health-maintenance behaviors. This finding is in support of existing research demonstrating that women with disordered eating behaviors generally are more external in their locus of control, and experience feelings of confusion and helplessness surrounding their sense of agency over their health (Grisham et al., 2016; Rance, Clarke, Moller, Wright, & Wyatt, 2016). This finding suggests that women who continue to demonstrate an external locus of control surrounding their physical health may be at higher risk of engaging in disordered eating behaviors during pregnancy, and supports the need for further research examining the relationship between helplessness and health-maintenance behaviors among this demographic.

Similar to Kaitlyn and Naomi, Jennifer experienced a lack of agency over her body during pregnancy, which was facilitated by medical complications. However, this experience played a less significant role in her overall narrative of pregnancy when compared to that of Kaitlyn and Naomi. Though she described her body in a way that was suggestive of disconnection, she spoke positively about its ability to create and carry a child, and demonstrated

a greater level of trust in its abilities. Jennifer may have had more access to coping mechanisms when faced with concern about the health of her child during pregnancy due to the fact that she had not previously experienced a miscarriage. Though she did not describe her experience of a lack of agency over her body as having a significant impact on her experience of pregnancy, Jennifer did describe how regaining control over her body was partly responsible for the distress that she faced during the postpartum period when her son would not latch to her breast. She ultimately attributed her son's failure to latch to a resurfacing of AN behaviors. A significant amount of research has supported similar findings surrounding breastfeeding challenges in women with a history of AN (Fogarty et al., 2018; Lowes et al., 2012, Katz & Vollenhoven, 2000), as well as a high rate of symptom relapse in the postpartum period (Taborelli et al., 2016). The present study supports the need for vigilance in the close monitoring of women who have a history of AN during the postpartum period, with particular attention to breastfeeding support options.

Rigidity vs. Restriction: Lingering AN voice and inflexibility during pregnancy. Rigidity and inflexibility are typical features of AN and account for many AN related thoughts, including: (a) categorizing foods as good or bad (i.e., black and white thinking); (b) ritualized eating and exercise patterns; and (c) difficulties in finding alternative ways to deal with problems (Aloi et al., 2015; Foerde & Steinglass, 2017). In the current findings, rigidity itself arose as a residual lingering AN symptom that carried into two out of three of the participants' eating and exercise behaviors during pregnancy. These behaviors did not appear "resurface" due to the nature of pregnancy, rather they seemed to be altered manifestations of patterns of rigidity that carried over into remission. This is commensurate to the existing research surrounding the cognitive processes and restrictive, or compensatory, behaviors that exist in women who have

achieved weight restoration for a sustained period of time (Clausen, 2004; Espindola & Blay,2013; Fichter et al., 2017; Foerde & Steinglass, 2017; Pike, 1998;).

Rigidity surrounding diet and health. In the present study, all three participants reported being able to develop healthful prenatal eating behaviors. However, two of the three participants described engaging in behaviors that were characteristic of AN symptomology, and reported doing so in the absence of the fear of weight gain. Rather, participants experienced the behaviors as either playing new, positive roles (e.g., Kaitlyn's strict adherence to "safe" foods) or, as fixed, benign features of their personality (e.g., Naomi's rigid eating patterns). Despite evidence that their eating behaviors may have restrictive tendencies (i.e., Kaitlyn's therapist expressing concern), or compromising the health of their child (i.e., Naomi's partial adherence to guidelines from nutritionist despite recommendations to gain more weight), participants' rigid dispositions made it challenging for them stray from these patterns.

The findings of the present study tie in well with that of previous studies wherein pregnant women with a history of ED fine-tuned their eating habits in order to appease both the needs of their eating disorder, as well as the needs of their developing child (Fogarty et al., 2018). Both Kaitlyn and Naomi tailored their eating behaviors in a way that they felt supported the health of their pregnancy, as well as decreased emotional distress associated with a lack of autonomy over their body. Differences were, however, demonstrated with regard to the degree to which Kaitlyn and Naomi were able to find this balance. Despite her hypervigilance surrounding dietary safety, Kaitlyn was able to gain the recommended pregnancy weight. In contrast, Naomi was unable to meet weight recommendations, and struggled to meet the caloric demands of pregnancy in the face of her rigid dietary patterns. Jennifer was not represented in this category, given the absence of reported rigid or restrictive behaviors during pregnancy. Exploring these

differences helps to shed light on some of the possible facilitating factors underlying the severity and form of restrictive behaviors during pregnancy.

One possible way to understand the differences in the degree to which rigidity played a role during pregnancy among participants is by exploring the underlying source of distress, or threat to control, that triggered the maintenance of inflexibility. For example, one could postulate that Kaitlyn's distress was directly correlated to her anxiety surrounding the health of her baby, which was compounded by a general sense of lack of agency over her pregnancy. Being that her pull for control was correlated with her desire to maintain the health of her child, her rigidity manifested in behaviors that would support that goal.

In contrast, Naomi did not experience a high degree of anxiety surrounding the health of her child and was ultimately more disconnected from the pregnancy experience as a whole. Thus, her efforts to maintain rigid pre-pregnancy eating behaviors were not as strongly modified by the motivation to support the health of her child. Rather, Naomi experienced distress caused by AN cognitions that resurfaced in her attempts to break out of her pre-pregnancy eating routines. It could thus be hypothesized that women who experience distress surrounding the health of their baby are less likely to develop harmful compensatory behaviors, versus women who experience distress during pregnancy that is more self-focused in nature. Conversely, it could be hypothesized that women who experience distress surrounding the emotional impact of the dietary challenges of pregnancy are at risk of developing harmful compensatory behaviors or maintaining restrictive behaviors that exist pre-pregnancy. Additionally, one could also postulate that Kaitlyn's involvement in psychotherapy throughout her pregnancy may have aided in her ability to meet weight recommendations, while Naomi's lack of involvement impaired her ability to do so. Further research should explore whether there is a correlation between engagement in

psychotherapy during pregnancy and ability to meet weight-recommendations among this population.

Recommendations. The desire for control among women with a history of AN can remain present throughout pregnancy, and the behaviors that women engage in to regain a sense of control appear to be derived from the specific areas where women experience a lack of agency. Healthcare providers should aim to achieve greater insight into the role and impact of rigidity on the eating behaviors of their patients during pregnancy, as well as the relationship between rigidity and the desire for control. Providers can do so through a general exploration of the thought processes associated with the rigid behaviors. For example, women who are severely anxious about the health of their baby may be prone to misinterpreting or overvaluing the dietary guidelines and restrictions associated with pregnancy, and thus develop restrictive eating behaviors that may not be medically indicated. Healthcare providers should thoroughly explore women's understanding of nutritional guidelines, gauge whether their level of adherence is reminiscent of distorted cognitions or overvalued ideas, and attempt to rectify or correct any inaccurate information. For women who experience distress surrounding the demands of pregnancy that is more self-focused in nature, their healthcare providers might explore their level of understanding with regard to the impact of their behaviors on their developing child. In such cases, providers should also explore whether there are preconceived notions that their patients have about their degree of agency surrounding their own physical health, and provide corrective education.

Avoidance of the use of the word restriction. Two out of three participants explicitly demonstrated resistance or refusal in the utilization of the word *restriction* when characterizing behaviors that they self-identified has having restrictive traits. More specifically, Kaitlyn and

Naomi experienced their eating behaviors as having remnants of restriction, yet did not wish to characterize them as such given that they existed in the absence of the fear of weight gain. The behaviors instead were characterized as serving to keep the baby safe from dangerous foods (Kaitlyn), and to prevent physical and emotional discomfort that would result from breaking out of rigid pre-pregnancy dietary patterns (Naomi). Despite the fact that these behaviors were re-characterized, they still served to ease the anxiety and distress experienced by the mother, and thus may not have always been done with regard to prenatal nutritional guidelines.

Recommendations. In light of the findings of the present study, it could be postulated that the context of pregnancy may disguise disordered behaviors by providing a new lens through which women rationalize or understand them. This creates an obstacle for medical and mental health providers, in the sense that renamed or reframed behaviors that are reminiscent of restriction may go undetected and pose the risk of harming the health of the mother or child. As such, healthcare providers should remain cognizant of the more nuanced forms of restriction (i.e., eating foods with low caloric density, eating only healthy foods, restricting entire food groups) and inquire about specific details surrounding eating habits to gauge whether they support or pose risk to pregnancy.

Continuation of rigid patterns surrounding exercise. Commensurate to the findings of Micali et al. (2007), two out of three participants reported having continued highly regimented exercise habits well into their pregnancies. Kaitlyn and Naomi both attempted to continue with their pre-pregnancy exercise regimen until they were physically incapable of doing so. While both participants described their exercise behaviors as having a different function than was once had pre-remission (i.e., not for weight loss), both attributed their strict adherence to be related to lingering remnants of their history with AN.

Research surrounding the time course of symptom remission in eating disorders has found that excessive exercise often persists after remission has been met, despite the general expectation of behavioral symptoms remitting before the psychological and physical symptoms of AN (Clausen, 2004). This may account for the fact that both participants still continued to engage in ritualized and rigorous exercise behaviors post remission, despite the goal of the exercise being unrelated to weight management. In the present study, the participants who engaged in rigorous exercise during the prenatal period did not appear to consider the implications that excessive exercise could have on their pregnancy, and discontinued or modified their routine based on physical limitations and discomfort. This is in contrast to the findings of Tierney et al. (2011), in that participants in that study indicated that they altered their exercise behaviors out of concern of the health of their baby. It is possible that, given the general positive emphasis that is placed on exercise, the possible risks associated with over-engagement in it are overlooked by women in this population.

Similar to the findings of Tierney et al. (2011), participants in the current study described how exercise played a role in their emotional regulation, and provided examples as to how the forced modifications to their routine could negatively impact their mood. The culmination of the current findings in the context of extant literature suggests that women with a history of AN are at risk of utilizing excessive exercise as a means to cope with their distress and fulfill their desire to maintain control. This may occur unknowingly to individuals, as the behavior itself is not inherently pathological when in absence of methods of caloric restriction or without the explicit aim to manage weight. However, there are still risks associated with engagement in excessive exercise during pregnancy, especially in pregnancies of which are high-risk (“Pregnancy and Eating Disorders,” 2015). Additionally, excessive exercise may indicate that a woman is

beginning to relapse, or is at high risk of relapsing, into her disordered eating behaviors (Carter et al., 2004).

Recommendations. Healthcare providers should be familiar with the role of excessive and ritualized exercise in the context of AN in general, and are encouraged to monitor these behaviors in patients during the prenatal period. They should inquire not only about the frequency and type of exercise that women engage in during pregnancy, but explore the role that exercise played in their life prior to pregnancy (i.e., weight management, emotional regulation, cardiovascular health, etc.) Additionally, healthcare providers should monitor for emotional and psychological distress in the face of exercise modifications during pregnancy.

Differences among participants. Differences among participants, with respect to rigidity in eating and exercise behaviors during pregnancy, might indicate a correlation between the degree of rigidity in behaviors prior to pregnancy, and the development and maintenance of such behaviors during pregnancy. Research has demonstrated that women with a history of AN struggle to break out of rigid behavioral patterns, and require a significant amount of time to do so (Aloi et al., 2015). In light of the findings of this study, it could be hypothesized that women who engage in rigid, rigorous, exercise patterns directly prior to pregnancy are more likely to struggle with the behavioral adaptations and alterations that pregnancy requires. The same could be hypothesized for women's relationship with food prior to pregnancy.

A more general explanation for differences among the participants in this superordinate theme could be that there is a relationship between the time spent in remission prior to conception, and the degree to which disordered eating and exercise behaviors become present during pregnancy. In the current study, Jennifer had been in remission for the longest length of time, and was the only participant who described having been in full remission at the time of

conception. When compared to Kaitlyn and Naomi, Jennifer reported a lower degree of rigidity in her eating and exercise behaviors during pregnancy. Given that women who are in partial remission still experience either an intense fear of gaining weight, behaviors that interfere with weight gain, and/or disturbances in self-perception of weight and shape (American Psychiatric Association, 2013), it is logical to hypothesize that they would be at higher risk for carrying such symptoms into their pregnancy. As such, future research should be conducted surrounding the correlation between remission status, length in remission, and the degree of rigidity and/or AN symptoms during pregnancy. Additionally, the findings of this study support the need for diligence when categorizing partial versus full remission among women of this demographic, specifically when it involves discussing remission status with patients.

Pregnancy positively impacts some aspects of relationship with food and body image. Similar to the findings of Fogarty et al. (2018) and Taborelli et al. (2016), participants in the current study identified ways in which their relationships with food and reactions to bodily changes were positively influenced by the new context that pregnancy provided. In general, identifying as a pregnant woman appeared to provide a sense of comfort and intrinsic acceptance among participants. With regard to food, participants described a motivation to support the health of their baby as newfound justification for an increase in caloric consumption and variety in their diet. Additionally, the societal expectation of weight gain during pregnancy was cited as providing some reprieve from restrictions surrounding food. In regard to body image, the temporary nature of pregnancy, as well as appreciation for their body's reproduction abilities, were cited as counteracting the negative feelings associated with bodily changes.

Recommendations. Healthcare providers can capitalize on the protective factors that have been associated with the *pregnancy identity* by consciously creating a foundation from

which women are able to positively contextualize their pregnancy experience. For example, providers should focus on helping women to develop feelings of empowerment and competence surrounding pregnancy and motherhood early on in their experience. The concept of 'empowerment' can be understood as the "development of the ability to put one's own life and identify in a new perspective" (Espindola & Blay, 2013), and has been identified as a skill that is necessary in the maintenance of remission from AN (Espindola & Blay, 2013). By providing a woman with access to tools, education, and support surrounding the pregnancy experience and transition into motherhood, the identity associated with motherhood can be more readily integrated into her sense of self. Subsequently, the integration of the motherhood identity into her sense of self will increase her sense of empowerment and aptitude in that role, and result in the development of health-maintenance behaviors that align with it.

Environmental stressors impair level of engagement in self-care behaviors. Two participants in this study cited external events and environmental stressors as having greatly overshadowed their pregnancy experience. Though participants did not directly link a resurgence of disordered eating behaviors to these external stressors, they did experience their ability to self-monitor and engage in self-care behaviors to be impacted. Jennifer's pregnancy was unplanned, requiring her to take measures of environmental alteration in order to prepare for the arrival of her child. Doing so impacted her ability to self-monitor, and impaired her ability attend to a serious health complication. Similarly, the external circumstances that Naomi faced impacted her ability to self-monitor her well-being, and stay fueled and rested. Additionally, Naomi experienced a lapse in her prenatal care due to the demands of an out of state move

Given that research supports a correlation between stress, life transitions, and the development or resurgence of AN symptomology (American Psychiatric Association, 2013;

Berends, van Meijel, & Elburg, 2012; Katz & Vollenhoven, 2000), it is important to consider the impact that circumstances extraneous to pregnancy may have on women with a history of AN. More specifically, the impact of external stressors on the degree of connection between mind and body among women with a history of AN should be explored further. Research has demonstrated that women who suffer from AN also experience a disconnection from their body and health (Skårderud, 2007). It could be postulated then that the demands of external stressors may exacerbate this disconnection and leave women of this demographic at higher risk of overlooking health complications.

Additionally, women who experience significant environmental stressors during their pregnancy may experience a greater disconnection from the experience of pregnancy itself. As a result, women may then be at higher risk of falling back into disordered eating, as they are less likely to consider the impact of their behaviors on their developing child. For example, Naomi described her pregnancy as being a secondary thought to the immense responsibilities and stressors associated with the emotional and pragmatic process of grieving her mother-in-law. In light of the research that demonstrates how "thinking of the other," or thinking of the health of one's baby, stands as a protective factor among women with a history of AN (Patel, Wheatcroft, Park, & Stein 2002; Tierney et al., 2011), it could then be hypothesized that Naomi's disrupted ability to attend fully to her pregnancy may have made it more difficult for her to give up potentially harmful eating and exercise behaviors.

Healthcare providers should be consistent in their monitoring of patients' external stressors during pregnancy. Given the high rate of unplanned pregnancies among women with a history of AN (Tierney et al., 2011), providers should assess the degree to which their patients feel prepared for the arrival of their baby, and make referrals to appropriate supportive agencies

if indicated. Providers should also educate women about the effects of stress on pregnancy, and help them to develop self-care and self-monitoring skills.

Social relationships have significant influence on formation of self-perception and engagement in health-maintenance behaviors.

Satisfaction of body strongly influenced by positive and negative feedback. The findings of this study suggest that participants possessed an external locus of self-evaluation that, at times, jeopardized their body satisfaction. In contrast to Tierney et al. (2011), participants in this study were generally ambivalent about the changes that took place in their bodies during pregnancy, and did not report significant body dissatisfaction. However, participants did describe their intrinsic acceptance of bodily changes being, at times, counteracted by comments from others about their increasing weight or body shape. Research has demonstrated that women who are in recovery from AN often continue to be sensitive to comments directly targeting weight gain (Lamoureux & Bottorff, 2005). Pregnancy could then be postulated to be a particularly sensitive time for women in remission given the higher likelihood for conversations surrounding weight gain. Additionally, women who are in environments where intergenerational disordered eating is present may be at particularly high risk of developing a greater sense of body dissatisfaction.

Desire for prominent pregnancy features. As has been found to be true in similar qualitative studies (Taborelli et al., 2016; Tierney et al., 2011), participants placed emphasis on the development of a prominent baby bump, as it made it clear to the external world that they were pregnant rather than just overweight. Participants felt less impacted by the external perception of weight gain when they were confident that those around them could directly attribute their changing body to pregnancy. It is of no surprise then that participants felt most negatively about their bodies during the early stages of pregnancy, when they experienced their

weight gain as being less obviously attributable to pregnancy.

Spouse plays important role in monitoring and engaging in health-maintenance behaviors. Concurrent with the findings of existing research (Tierney et al., 2011), participants in the present study identified their spouse as having been their primary social support during pregnancy. Participants in the present study also described their husbands as being fully aware of their history with AN, thus actively helping to monitor and manage healthy eating and exercise behaviors. Additionally, participants described how positive feedback from their spouses helped them to rationalize concerns about weight gain. This finding is particularly important, as it highlights the importance of transparency surrounding AN with close, trusted, social supports. Intimate social relationships have been cited as a primary protective factor in the process of recovery from AN (Jagielska & Kacperska, 2017; Lamoureux & Bottorff, 2005; Taborelli et al., 2016). Therefore, it is likely that having a supportive partner during pregnancy serves as a protective factor against the resurgence of AN symptoms among women with a history of the disorder. Conversely, women who are single, or whose partner is not present or supportive during pregnancy (e.g., women whose partners are in the military, long-distance relationships, etc.), may be at higher risk of falling back into disordered eating.

Recommendations. Medical and mental health providers should remain cognizant of the impact of social relationships and the influence of external perception on the self-esteem and self-care behaviors among women pregnant women with a history of AN. With regard to body satisfaction, healthcare providers should consider the first and second trimester as a time of high risk for women with a history of AN given the onset of weight gain. Special attention should be paid to patients' emotional reactions to the initial stages of weight gain. Similarly, the first trimester of pregnancy should be seen as an opportune window for prevention and intervention

wherein healthcare providers help prepare women for the bodily changes that will take place. During this time period, mental health professionals should implement interventions targeting self-esteem enhancement and emotional regulation. Lastly, healthcare providers should remain cognizant of the importance of close social relationships as a protective factor against the resurgence of AN symptoms. Providers should closely monitor women who appear socially isolated, or are without a partner throughout their pregnancy. Women who are pregnant should be encouraged to share their history of AN with their spouse, family members, and friends. Additionally, supportive counseling should be provided to social supports surrounding the symptoms of AN, indicators of symptom resurgence, and caregiver burnout.

History of AN minimized during routine prenatal medical care. The findings of this study revealed a minimization of the role of mental health providers during the prenatal period, and a reliance on medical providers to assess, monitor, and manage symptoms associated with participants' histories of AN. Professionals in the field of psychology and psychiatry are provided with more detailed training surrounding AN than obstetricians who do not specialize in high risk or psychiatrically complicated pregnancies. Given that AN is a psychiatric diagnosis, the over-reliance on medical providers who were not specialized in AN created gaps in the prenatal healthcare experiences of participants in this study. This finding highlights the importance of the integration of mental health providers in primary care and OBGYN settings.

Minimization or absence of the role of mental health providers during pregnancy. Given the chronicity of AN (American Psychiatric Association, 2013) as well as the prevalence of postpartum depression (Franko et al., 2001) and symptom relapse among this population (Kouba et al., 2005; Micali et al., 2007), ongoing mental health support during pregnancy is highly supported. However, the findings of this study suggest that the utilization of mental health

treatment may be minimized in women who become pregnant while in remission from AN. Specifically, two out of the three participants did not receive mental healthcare throughout their pregnancy, and the one participant who did engage in therapy appeared to minimize her therapist's nutritional advice, despite her pervasive anxiety and rigidity surrounding food safety.

Given that the women who participated in this study considered themselves to be in remission from the disorder, it is possible that they did not see a need for therapeutic intervention. To my knowledge, there has not been research conducted that focuses on the rates at which women who become pregnant while in remission from AN receive psychiatric treatment. This is an important group clinically, as women in remission from AN may not still be linked to mental health services, and therefore may be less likely to have access to the specialized help that they need. Additionally, as demonstrated in the present study, women with a history of AN may, themselves, struggle to link heightened levels of distress surrounding the dietary demands of pregnancy to pathological underpinnings. Future research should explore the rates of which this group engages in mental healthcare during pregnancy, and identify whether there are specific reasons underlying a lack of engagement, should it exist.

Mental health and emotional well-being are addressed in reactive versus proactive manner. The minimization or absence of mental health treatment during pregnancy generates a heavy reliance on obstetricians and other physicians involved in prenatal care to adequately identify and address psychological remnants of AN during pregnancy. The findings of this study suggest that this notion, in itself, is wrought with insufficiencies, and highlights the need for the integration of mental health care providers in OBGYN and primary care settings. Namely, despite their disclosure of their histories, participants described a general dismissal or lack of follow-up regarding their AN diagnosis by their obstetricians. Furthermore, there was a lack of

inquiry into participants' general social–emotional well-being, and a heavy reliance on weight as the determining factor of overall well-being and health maintenance. In the instance where an obstetrician did inquire further about a participant's history of AN, it was only done toward the end of pregnancy, and in a reactive manner. Additionally, physicians' attempts to address concerns surrounding mental health were received poorly by participants and generally resulted in little change. This finding is significant, as all three participants expressed experiencing emotional distress during pregnancy that impaired their functioning to some degree.

In the present study, participants attributed their obstetricians' lack of attention to their history of AN as confirming their well-being and remission status. This is indicative of the emphasis that women place on the advice and assessment of their medical providers. Ultimately, this reliance on physician assessment and the general silence surrounding participants' history of AN creates the foundation for women to internalize self-affirming biases (e.g., "If the doctor didn't ask about my eating habits, that must mean that I am gaining enough weight, which must mean that I am eating adequately and exercising with moderation, which must mean I'm in remission"). Women who have been interviewed in similar qualitative studies have provided accounts of their history of AN being overlooked or dismissed by their medical providers (Bye et al., 2018; Shaffer et al., 2008), and have linked instances of symptom relapse to their doctor's lack of expressed concern (Shaffer et al., 2008). Similarly, physicians have been cited as taking a reactive rather than proactive approach with regard to psychiatric treatment for pregnant women with a history of ED (Mazer-Poline & Fornari, 2009).

Desire for more monitoring and exploration of emotional well-being by medical providers. Participants in this study described feeling as if their doctors should have taken more care to monitor or check in with them in regard to their emotional well-being, especially in light

of their history with AN. Existing literature suggests that systemic obstacles and lapses in medical training make it challenging for healthcare providers to identify and address psychological issues relating to AN among pregnant women (Bye et al., 2018). These systemic obstacles may account for the lack of exploration discovered in the present study. Bye et al. (2018) examined the barriers to identifying eating disorders in pregnancy and in the postnatal period. Health professionals who participated in the study reported having received minimal to no training on ED as part of their clinical education. Most of the health professionals who partook in the study described their understanding of AN as being limited to food restriction, and reported being unaware of the implications of the disorder on the health of pregnancy. Additionally, they felt unsure of whether it was their role to identify or manage ED symptoms.

Recommendations. Given that obstetricians and other qualified medical professionals are trained primarily to monitor physical health, it is understandable that they would place high emphasis on weight gain when considering the possible impact of AN on their patients' pregnancy. However, the reliance solely on weight as an indicator of remission status and engagement in health-maintenance behaviors can be misleading. Research has demonstrated that women who have achieved weight restoration often continue to suffer from psychological and behavioral remnants of the disorder including heightened sensitivity to comments about weight, lingering cognitive distortions, desire for control, impaired emotional regulation, restrictive eating behaviors, fasting, and intense exercise routines (Clausen, 2004; Espindola & Blay, 2013; Fitchter et al., 2017; Foerde & Steinglass, 2017; Pike, 1998). As such, it is essential that pregnant women with a history of AN are monitored by a team of medical and mental health providers who can thoroughly assess the clinical picture in its entirety. For example, the onset of prenatal care should include not only verbal inquiry, but the administration of a screening tool designed to

detect historic or current presence of AN symptomology. If detected, medical providers should engage in exploratory inquiry that assesses the details of a patient's experience of AN to identify potential signs of resurgence as the pregnancy proceeds, and to assess the patient's recovery status. Additionally, medical providers should link patients with a history of AN to a psychologist or therapist who specializes in the disorder.

It is essential for mental health providers who work with women with histories of AN to emphasize the importance of long-term follow-up and educate their patients on the risks associated with AN symptomology during pregnancy. Additionally, it is important that obstetricians and other medical providers who play a role in prenatal care be well versed in the diagnosis of AN, cognizant of the chronic nature of disorder, and educated on nuanced forms of AN symptom resurgence. It is also important to consider how *shame* may impact the degree to which women openly disclose an AN diagnosis at the onset of prenatal care, as they may fear that it reflects poorly on their ability to care for their pregnancy and child. Healthcare providers should educate women on the importance of patient–provider transparency, and alleviate their concerns about disclosure by treating the screening process as a routine preventative-care measure that will not impact the way in which they are viewed or treated by their healthcare team.

Ultimately, the findings of this study suggest that there may be extremely high value in an integrated care approach to obstetrics and gynecology wherein medical and mental health professionals work collaboratively under the same roof. The mental health field should continue to advocate for the roles of psychologists and psychiatrists within medical settings, and consider how the lack thereof may result in obstetricians and gynecologists being asked to practice outside of their scope of competence. Given that AN is a psychiatric diagnosis with significant impact on

physical health, it should be viewed as a disorder where medical and mental health professionals must work together to implement successful preventative interventions. Specifically, the findings of this study support the recommendation made by Lowes et al. (2012), which is as follows:

> Women with active or previous anorexia nervosa should have intensive obstetric care from a multidisciplinary team comprising an obstetrician with an interest in high risk pregnancy, an experienced midwife, a dietician, an eating disorder specialist, a perinatal mental health team, the woman's general practitioner, an imaging specialist and an obstetric anesthetist. (p. 184)

Limitations & Future Directions

As transparency is essential to all scholarly research, it is necessary to discuss the limitations of the present study, as well as their potential implications for the results. Perhaps the most notable limitation concerns the small sample size. I initially set out with the intention of interviewing a larger number of participants, however, faced several obstacles limiting my access to participants. It is possible that the very nature of AN, being a diagnosis that is highly stigmatized and often associated with shame, limited the likelihood of women's willingness to disclose their experience. Another factor that likely impacted participant access was the practical circumstances surrounding the timeframe during which I was recruiting for participants. Specifically, I engaged in multiple re-locations, making it difficult to consistently follow up and encourage providers to recruit participants. However, I did move the study forward, given that an adequate sample was established in order to thoroughly implement IPA and fulfill the purpose of the study.

A second limitation is the reliance on self-reported psychiatric history and remission status to identify participants for this study. Though all participants reported having been

clinically diagnosed with AN in the past, only one participant was referred directly by a psychologist who confirmed the diagnosis. The participants themselves were not required to provide documentation of their psychiatric history. Additionally, participants were not asked to disclose their specific weight at the time of pregnancy, thus their remission status was also based on self-report. As such, the possibility of inaccurate reporting of diagnosis or remission status could have potentially impacted the results of this study. Verifying the psychiatric history and remission status of participants would strengthen the dependability and credibility of this research.

Similarly, the overall reliance on retrospective self-reported accounts of participants' experiences should be taken into consideration when pondering the results of this study. As private self-reported data cannot be independently verified, there is potential for a number of biases to impact the information that was provided by participants during the interviews. For example, participants' responses may have been influenced by selective memory (i.e., remembering or not remembering experiences or events that occurred during their experience), telescoping (i.e., recalling events out of order, or out of the timeline of the phenomena of inquiry), or social desirability (i.e., answering questions in a way that positions one to be liked or accepted; Brutus, Aguinis, & Wassmer, 2013).

Lastly, the aforementioned limitations should be taken into consideration when considering the recommendations provided in this study. Specifically, the recommendations were based on the experiences of three women, and thus not adequate to generalize to the demographics as a whole. Additionally, the recommendations that have been made have not been tested, therefore future testing of each recommendation is needed in order to gauge their efficacy.

It is my belief that these limitations ultimately do not make the results of the study less

meaningful; as the captured experiences came from women who personally identified as being in remission from AN, thus the way that they made meaning of their experiences was influenced by that self-conceptualization. Future research exploring the subjective experience of pregnancy among women in remission from AN should aim to include a larger sample size and should be conducted using similar methodology while utilizing a prospective versus retrospective design. Additionally, future research on this topic would be strengthened with the added conditions of documented psychiatric history and verified remission status at the time of pregnancy. Moreover, research should be conducted surrounding the accuracy of self-assessed remission status among women who become pregnant with a history of AN, as the inaccurate identification itself likely leads to additional risk factors for this population when considering access to specialized treatment and women's subjective view of their eating and exercise behaviors.

Reflection and Final Thoughts

Researcher's Reflection of Research Process

Throughout the research process, I found the most challenging component to be learning to trust my clinical intuition without fear of misidentifying themes or making incorrect assumptions. I understood IPA to be a process wherein I was meant to move further and further away from the individual transcript data toward a broader conceptualization grounded in my own interpretation, of which is influenced by clinical expertise. The process was fascinating, if not a bit terrifying. In my clinical work providing therapy, I constantly use my own subjective interpretation of "data" as "evidence" of greater themes, however the weight of doing so in the format of a scientific study felt greater.

During my initial attempt to analyze the first interview, I found that I rarely strayed from descriptive comments, and focused more on facts within the transcript that I could readily

defend. The results of this initial attempt felt bare and sterile. In response, I began to internally process my resistance to making deeper interpretations. I was hardly surprised to find that one of my first concerns was, “What if I’m wrong?” Secondly, I realized that I was concerned about how my clinical background may, too quickly, have resulted in my pathologizing of intimate experiences that participants shared with me. In an attempt to resolve these concerns, I eagerly checked and rechecked my self-reflective journal to assess the impact of my preconceived notions of the subject matter, interview content, participants, and interviews themselves.

When I was about halfway through the process of analyzing the second interview, I realized that my habit to refer to my self-reflective journal had become a compulsive tool of reassurance seeking. In other words, it was my attempt at trying to counteract my own insecurities of being an inexperienced researcher who at times felt in over her head. My habit of referring back to my reflective journal became a tool to rectify my fears about how my inexperience as a researcher might impact both the quality of my dissertation, and the ways in which I portrayed the women who participated in the study.

Realizing that my own insecurities as a novice researcher were inhibiting my ability to engage, as deeply as I’d wanted to, with the data was transformational. Following this realization, I revisited the first transcript and reanalyzed the data again, but this time did so with the notion of a “clinical gut” in mind. Throughout the process, I realized that my immersion with the data was not so different than my immersion with a client’s story in the therapy room. I realized that I’d already encompassed the foundational tenets of phenomenological and idiopathic research, in the sense that I genuinely listen, try to understand, and empathize with the stories that others share with me. I felt confident that with the employment of my clinical skills in addition to the methodological efforts to increase credibility and dependability, I could

successfully complete this research endeavor. More importantly, I felt a renewed sense of confidence in my own clinical gut as a guiding force that will serve me as I transition out of my role of student and into my role as an early career psychologist.

Final Thoughts

Pregnancy is said to be one of the most metamorphic times in a woman's life. For almost an entire year, a woman's body transforms from a vessel that exists solely to sustain her survival, to an incubator that carries, protects, and nourishes a fragile new life form. Conversely, AN encourages a woman to exert rigid control behaviors at the cost of her own health, whereas pregnancy requires a woman to actively engage in behaviors that support her baby's health. Though the symptoms of AN can subside, the disorder is chronic, and the imprints of its former existence can remain visible even once weight is restored.

According to the present study, the remnants of AN can show up during the pregnancy experience in forms that may not be readily recognizable to expectant mothers or their medical providers. Though the nature of rigid or restrictive behaviors may shift in effort to support the life of a growing baby, the emotional function of the behaviors remains similar. Pregnancy provides women with a history of AN with a new sense of meaning in relation to nourishing their baby as well as their own their body. However, their efforts to do so may, at times, be undermined by the pull to maintain control and regulate emotional distress through eating, exercise, and other compensatory behaviors that were similar to those that were present prior to remission. The narratives produced by participants in this study highlight the necessity of strength and courage that women must manifest to adequately support the health of their child in the face of monumental changes, forced transitions, and lingering cognitive distortions.

Overall, this study underlines how important it is for medical and mental health

professionals to understand and appreciate the nuances and complexities of AN, both pre- and post-remission. In order to support women in the ongoing battle against their *lingering AN voice* during pregnancy, we must be cognizant of the likelihood that it exists in some form, and we must explore what it is saying, whether it is loud and clear, or just a discreet whisper.

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Appendix A

Interview Prompts

1) Please tell me about your history with AN
   Prompts:
   a. When was the onset of AN?
   b. How would you rate the severity of AN?
   c. What was your lowest weight?
   d. What were your symptoms?
   e. For how long did you experience AN?
   f. Were you ever hospitalized for AN? For how long?
   g. What, if any treatment did you receive for AN?
   h. Tell me about any remission or relapse experiences you had with AN?
   i. What was the recovery process like?
   j. What was it like to gain weight?
2) Please tell me about your experience of the pregnancy
   Prompts:
   a. How long were you in remission from AN when you became pregnant?
   b. Was the pregnancy planned?
   c. When you found out you were pregnant, what did you feel like emotionally?
   d. What were the most enjoyable/least enjoyable/easy/hardest parts of pregnancy?
   e. What response did you have from your family when you became pregnant?
   f. Were there specific moments during your pregnancy that were the most meaningful to you?
   g. What was it like to feel the baby inside of you?
   h. What was it like to think of the baby?
   i. Did you have a birthing plan? What was it?
3) Please tell me about your relationship with food and exercise during your pregnancy
   Prompts:
   a. What were your exercise habits during pregnancy? Before Pregnancy?
   b. How did your relationship with food change during pregnancy?
   c. What cravings did you experience? How often did you listen to your cravings?
   d. In what ways did you follow or not follow the nutritional advice of your obstetrician/Practitioner?
4) Please tell me about your relationship with your body during pregnancy
   Prompts:
   a. What did you notice about the way you felt about your body? When and how did you notice that?
   b. Tell me about a time when you felt particularly happy about your body?
   c. Tell me about a time when you felt particularly unhappy about your body?
   d. What bodily changes surprised you the most?
5) Please tell me about the support you had during your pregnancy
   Prompts:
   a. What kind of providers did you see? (obstetrician, doctor, psychologist, psychiatrist, midwife, etc.)?

b. Was your history of an eating disorder disclosed to your obstetrician?
c. Who supported you throughout your pregnancy?
d. Did you have a partner throughout the pregnancy?
e. Was there mention of concern throughout your pregnancy from those who supported you? Regarding to your physical health? Regarding your emotional well-being? Regarding your eating or exercise habits?

Appendix B

Sample Recruitment Flyer

VOLUNTEERS NEEDED FOR RESEARCH STUDY

Experience of Pregnant Women in Remission from Anorexia Nervosa

I am a doctoral student studying at Antioch University New England conducting research that explores the subjective experience of pregnancy among women who became pregnant while in remission from Anorexia Nervosa (AN). The aim of this study is to aid in a greater understanding of the experience of pregnancy in women with a history of (AN). I am looking for eligible participants to partake in one interview in person or over the phone that will last approximately 90 minutes.

Eligibility Requirements:

- Must be a female between the ages of 18-35
- Must have a history of clinically diagnosed Anorexia
- Must have become pregnant in the last five years while in remission from Anorexia

If interested, please contact me via email or phone using the contact information on the flags below.

Thank you!!

XXXXXXX xxx-xxx (xxx) xxxxxxx@xxxxxx.xxx	XXXXXXX xxx-xxx (xxx) xxxxxxx@xxxxxx.xxx	XXXXXXX xxx-xxx (xxx) xxxxxxx@xxxxxx.xxx	XXXXXXX xxx-xxx (xxx) xxxxxxx@xxxxxx.xxx	XXXXXXX xxx-xxx (xxx) xxxxxxx@xxxxxx.xxx	XXXXXXX xxx-xxx (xxx) xxxxxxx@xxxxxx.xxx	XXXXXXX xxx-xxx (xxx) xxxxxxx@xxxxxx.xxx

Appendix C

Consent to Participate in Research

I volunteer to participate in a research project by Meghan Butcher, M.S., supervised by Dr. Kathi Borden from Antioch University New England. I understand that the project will explore the subjective experience of pregnancy amongst women who became pregnant while in remission from Anorexia. I understand that I will be one of about 10 people in this study.

1. I am freely participating in this study. I will not be paid and I can stop at any time without any repercussions.

2. I will participate in an in person or phone interview with the researcher. The interview will be about 60 minutes.

3. I will be asked to remember (if past pregnancy), think about, and share my experiences of pregnancy. This information is sensitive and might be hard to think/talk about. If I feel uncomfortable at any time, I can stop. Also, if I feel that I cannot deal with my distress on my own, I can reach out to a mental health professional or health services agency.

4. I understand that my participation will be treated confidentially and all information will be stored anonymously and securely. All information appearing in the final report will be anonymous.

5. I understand that this research has been reviewed and approved by the Institutional Review Board (IRB) at Antioch University New England.

6. I have read this form and understand what the researcher has told me. I have had all my questions answered and I willingly agree to participate in this study.

7. I have been given a copy of this consent form.

Signature: _____ Date: _____
(My signature)

Signature: _____ Date: _____
(Researcher's signature)

Appendix D
Superordinate and Emergent Themes Chart

Superordinate Themes	**Emergent Themes**
Control as a Mechanism of AN	• N/A
Experiences of Lack of Agency over Body and Health of Pregnancy	• N/A
Rigidity vs. Restriction: Lingering AN Voice and Inflexibility	• Rigidity surrounding diet and health • Avoidance of the use of the word *restriction* • Continuation of rigid patterns surrounding exercise
Pregnancy Positively Impacts Some Aspects of Relationship with Food and Body Image	• N/A
Environmental Stressors Impair Level of Engagement in Self-Care Behaviors	• N/A
Social Relationships Have Significant Influence on Formation of Self-Perception and Engagement in Health-Maintenance Behaviors	• Satisfaction of body strongly influenced by positive and negative feedback • Desire for prominent pregnancy features • Spouse plays important role in monitoring and engaging in health-maintenance behaviors
History of AN Minimized During Routine Prenatal Medical Care	• Minimization or absence of the role of mental health providers • Mental health and emotional well-being are addressed in a reactive vs. proactive manner • Desire for more monitoring and exploration of emotional well-being by medical providers

Appendix E

Superordinate & Emergent Themes List with Corresponding Quotes

Superordinate & Emergent Themes	Quote
Control as a Mechanism of AN	"When I moved to my mother's house between eighth grade and ninth grade, I moved for high school, that's kind of when things started going downhill" "Yeah, and it just kept getting worse like … it was when I went to college, when I was on my own … the transition of coping … that's when things got even worse." "So when I went to grad school … the stress of grad school started, and I started to not be able to cope well. My coping mechanism was to fall back into disordered eating." "Yeah I just, I, I hadn't really gone there by choice and I felt kind of violated and uncomfortable I think. … and I think you know it's often a control thing for eating disorders. So I think like [pause] I don't know maybe that was just my way of maybe retaking control [laughs]." "I'm very much like a person that needs to be in control. And I think that that was a huge component of the eating disorder, because, I had so many things on my plate. I had this full time job, and I had part time school, and I was getting married. There were just so many things going on. … It was like a lot on my plate and I was like okay, I could control one thing, and that was my food intake."
Experiences of Lack of Agency over Body and Health of Pregnancy	"So my pregnancy was a very high anxiety pregnancy. Medically it was totally fine through and through from day one … but I was extremely, extremely anxious about every single thing that was going on. …, so because I think I felt like so out of control with the pregnancy, like I couldn't control what was going on, all the anxiety was around like the health of the baby [rather than weight or body image]." "[I felt] like something bad was going to happen. Something bad had happened to me the first time, and like something bad was going to happen again. And I think that that was sort of like the root of the anxiety for the

	whole pregnancy. Like I had already had a loss, so like my body already had failed me once, so like of course it's going to happen again." "I don't gain weight very quickly ... but they wanted me to gain even more. I even like met with a nutritionist and I was trying to eat more but I just, I don't know my body was doing what it was doing." "Because I have a history with anorexia it did complicate things because we're trying to tease out what is just genetics and what is like eating behaviors. And so, the growth restriction was hard because, I, I personally was like well 'am I not doing as well as I think I'm doing?'" "I mean I think the biggest component [of distress at the end of pregnancy] was the anticipation [of birth], and of course my health. … My immune system was going to crap, everything was starting to get really bad." "But I think what really started the whole thing in terms of projecting my anorexia symptoms onto [my baby], was just, getting, getting control of the [medical problems]" "[The] way in which you might kind of sort of say there was a resurface wasn't actually with my own behavior or my own eating, it was around breastfeeding. When [the baby] refused to breastfeed, I couldn't just accept that, because breastfeeding was like part of my idea of being a mother. And I think I pushed it for way too hard for way too long. … My therapist kind of is associating that with my own need for control. … like somehow I have projected that onto [the baby]" There were like 5000 different things that should have made me preterm which was, of course, one of the biggest things that worried me throughout the whole pregnancy … There were a million things that should have made him really early. It's just really lucky that he came out exactly when he did because … if he had been a day earlier he wouldn't have been breathing on his own, if he'd come a day later I would have had to be put in surgery to get him out. So like it was perfect…I think the body knows a lot of things.

Rigidity vs. Restriction: Lingering AN Voice and Inflexibility Rigidity surrounding diet and health	"I was definitely very anxious or very cautious about my food intake when it came to, again, safety of the baby. Like checking that 'this is pasteurized and this is cooked enough' - there was a lot of anxiety around that. It wasn't so much like 'I can't eat a bagel or I can't have this donut' or whatever- it was just much more like 'is this fish or chicken cooked enough?' 'is this egg boiled enough? That kind of thing." "I mean if you asked my therapist she would tell you that I still had an eating disorder while I was pregnant, only because I was so, I was restrictive in a way that was ensuring the safety of the baby. So I wasn't eating foods that had any chance of having anything unsafe for the baby. Whereas my therapist told me that she would eat like deli turkey sandwiches like daily, and I was like 'you're insane." "The other thing that I really struggle with is I'm really concerned about healthy eating, and so probably one of my biggest struggles is, you know, indulging and things that may not be considered the most healthy thing to eat." "I was actually okay with gaining weight but I was like 'the foods that I'm eating better be healthy' and I wouldn't let myself eat anything that was… I would struggle and feel guilty if… I would eat something that was not as healthy." "If I eat like an unhealthy thing occasionally it's really probably not going to impact the baby, but with the eating disorder part of the brain, it doesn't allow you that leeway to be like 'okay every now and then this is okay'. So, just like eating it once or twice you know there, there's that kind of guilt or that kind of worry about like 'oh this is really unhealthy is it going to hurt me or hurt the babies health' and stuff like that." "I'm very rigid, let's put it that way, like I try to eat certain types of food, and I eat them like at certain times, and I don't like when I feel like I have to eat more. It's the hardest thing for me, with going to a nutritionist, having to get out of that rigidity. Like adding foods that I eat or adding in like textured snacks and extra food items that are not part of my normal, like my normal eating pattern"

Avoidance of use of the word restriction	**“**I don't call it restricting because it’s a known thing [to not eat specific foods when you’re pregnant]. To me that wasn't restricting, but I was definitely like overly cautious,”
	“I'm really good at eating a very set amount of food, but when I have to eat more I'm not. That's what's hard, it's the increased calories, I wasn't as restricting [as prior to remission], I was just, like, sometimes not eating more.”
Continuation of rigid patterns surrounding exercise.	“So I think that, that [her exercise habits prior to pregnancy] was the one thing that sort of remained constant. While I got pregnant, I wasn't exercising to lose weight, but I was anal about going to the gym. Like I had to go five days a week, six days a week, whatever it was. … And I stopped going to the gym at 38 weeks because I was just like 'I'm so enormous and I cannot do this anymore.”
	“I exercised throughout the pregnancy … I ran for as long as I could and then eventually I would get too big and uncomfortable so then I have to walk instead. … Before I got pregnant, I would run almost every day … and the first few months of pregnancy I kept doing the same thing as long as I could with my energy level. But some days I just like wouldn't. With pregnancy, the first trimester, you're very tired and I do remember one day feeling so tired that I just couldn't, I just couldn't run and I didn't. I just couldn't. It was probably midway through, over the course of pregnancy, what I started doing was running fewer days of the week so I would run a little bit like three or four days of the week.”
	“I definitely didn't force myself to go in the way I once did, but I definitely was adamant about going and made it a part of my day. I guess that, even though I viewed it a little bit differently, I just viewed it as being active versus like ‘let's lose weight’ - I definitely was very diligent about going. So I guess in a way that's sort of carried over with me into the pregnancy.”
	“I think that there are times that my relationship with exercise, … even when I'm pregnant, can be unhealthy because there comes a point in pregnancy where I would

	have to … modify things, and I have a really hard time doing that. Like slowing down and being like 'ok, you just need to walk instead of run … I know cognitively when I'm pregnant that, that it's a time to not overdo it. … but I would still have to work through some of those tendencies to exercise hard."
Pregnancy Positively Impacts Some Aspects of Relationship With Food and Body Image	"I really ate so many bagels and so many French fries when I was pregnant which was like something that I never even thought imaginable when I had an eating disorder," "Ironically, eating whatever I wanted," "I didn't mind having a belly, which is so bizarre because of the eating disorder. So I just, I didn't mind having this belly. ... I was just like - you know what? I'm pregnant and I eat bagels and cream cheese literally every day and it's awesome. It's what I'd been missing out on all these years when I was like so miserable and skinny" "When I'm just hurting myself, I have less motivation to change I guess," "When I'm pregnant its easier for me to logically think through 'well it's okay to eat this because my body needs it' like I'm growing another child and so like … I need energy, I need to eat in order to benefit the health of this child … being pregnant was like, another motivation to eat adequately, when [I'm] sustaining another life." "I don't really love eating meat. I do eat it sometimes, it's just not my preference, I'm more of a vegetarian type, but when I was pregnant I wanted to eat meat, and a lot more of higher fat higher protein foods, which I did. I just really enjoyed them and wanted them." **"**I definitely gained a significant amount of weight umm but I also didn't really care. I was just like 'I'll just deal with it later,' and like that was my mentality the whole time." "My body goes back to mostly normal really quickly so I knew the second time around that once I had the baby- I would not feel [negative about my body]. … I felt like kind of self-conscious, but, I don't know, it didn't really

	bother me. Like I was very able to [tell myself] 'There's nothing I can do about this. That was just the way it is and the way it was going to be, and it will go away once the baby is born.'" **"** I mean there was definitely some self-esteem stuff going on. I didn't feel great about how I looked, But there was also a component of being you know happy that my body could actually do something as amazing as creating a child you know?"
Environmental Stressors Impair Level of Engagement in Self-Care Behaviors	"[Becoming pregnant] was really exciting but crazy I mean it all kind of just, it's just a blur to be honest, it was just a blur of activity. … I just had a lot of stress, you know, and worrying about the environment that I was bringing [the baby] into. … but you know its just, trying to get everything to come together, it was crazy. You know, we weren't ready yet, so making it happen was definitely the hardest part of pregnancy." "[the third job] kind of pushed me beyond my limits with my kidney infection, and everything that I had been ignoring too long." "It was actually a somewhat stressful pregnancy because about two weeks before I conceived and became pregnant my mother in law died suddenly. … I spent much of the time that I was pregnant working through the loss. … and we had to clean out her entire house sell it and stuff like that. … , so a lot of my pregnancy was not even really thinking about the baby, I know that sounds terrible." "A lot of it was just focused on just getting done what we needed to do … it was just a lot of life changes. … I didn't really think about the pregnancy that much … the baby growing was just something that was just happening." "I did have a harder time keeping myself rested and fueled because we had so much life change happening. I don't think I took as good care of myself as I should have, but yeah, life happened."

Social Relationships Have Significant Influence on Formation of Self-Perception and Engagement in Health-Maintenance Behaviors	
Satisfaction of body strongly influenced by positive and negative feedback	"I got comments up the wazoo, [they'd say] 'You sure you're not having twins? You look like you're ready to pop' like every five seconds" "When [my family members] would make comments to me [about my weight], … I'd be like 'ok like I'll deal with whatever weight issue you all think that I have after I'm done being pregnant" … So at those times I would feel very uncomfortable." **"**[My husband] would always reassure me … like that like I'm beautiful, and I'm pregnant, and I'm beautiful at all sizes, and all that really nice stuff. So he was definitely my number one [support]." "My husband was really good about telling me that he enjoyed seeing me pregnant. … When I saw the other women my size, I think they're really cute … and to have my husband reinforce that that's how I looked and that it was cute. … It was just that positive reinforcement [that helped]."
Desire for prominent pregnancy features	"Oh well of course in like the second trimester especially. - that's kind of when you start just looking quote unquote fat, but it's not necessarily clear that you're pregnant yet - that was the toughest phase to deal with. When it was just like 'I just look fat, I don't look pregnant.'" "When I saw the other women my size -I think they're really cute because they're like, they're tiny and then there's this cute ball in the front, instead of just being like a blimp you know I so it was actually helpful to have [the baby bump]" "I was excited to like have this like big belly and whatever, Like I was like so excited about that. And it's funny because in the end like my belly wasn't so big, … so I was like oh ok my belly is like not so big but like everything else is big."

Spouse plays important role in monitoring and engaging in health-maintenance behaviors	"[Social support] is one thing I had going for me. I mean of course [my husband] was very supportive, he's of course the biggest source of support," "He was always like making sure that I was eating, like just because of my history. He would always just sort of like check and be like 'what did you have for lunch today?' Or if I like wasn't hungry for dinner, he'd be like 'well we have to eat something' like that kind of thing." "Okay umm so my husband was my biggest support person for sure, he's very like, he's very good about encouraging me to eat well and to exercise moderately … he's really good about working through a lot of the eating and exercise and even body image things. Biggest support person emotionally and mentally. "
History of AN Minimized During Routine Prenatal Medical Care	
Minimization or absence of the role of mental health providers	"Not in a very specific way. It was more like you need to nourish your baby… blah blah blah."
Mental health and emotional well-being are addressed in reactive vs. proactive manner	"I think I did bring it up with my OB in the very beginning, just because I was concerned about whether or not that might affect the pregnancy." "Yeah, I think it was my first intake with him when I first met him. … When he was sort of telling me about [ovulation] I was like, oh, 'you know I had an eating disorder,' like I sort of brought it up. It was a point that I felt he should know." "Umm yeah I must have disclosed that like at the very beginning when I was filling out the health history. " "No I mean I think not many people in my life even knew about it. I mean the medical people and my husband knew about it but, you know I wasn't having any symptoms there wasn't really, there wasn't really much reason for people to worry."

	"Even though I was fine considering ... my pregnancy and my weight gain, even though everything was fine, [my obstetrician] never checked in on it or asked about it." "No one ever really [discussed my history of AN] until there was a complication with the baby at the very like the last month," "My OB recommended when I was 37 weeks that I go on an anti-anxiety medication because I was super-duper anxious ... and he sort of wanted to nip that in the bud. ... I was very against that because I didn't want to take any medication while I was pregnant because I was anxious about it. So I ended up not doing that while I was pregnant. But he did, he did recommend that very strongly."
Desire for more monitoring and exploration of emotional well-being by medical providers	"I feel like … the [obstetrician] could have like asked me 'are you feeling ok with the food?' Even not necessarily like at every appointment, but once in a while - could of checked in on that." "I definitely think that there are people who are pregnant or trying to get pregnant, who had eating disorders or have eating disorders, that are triggered by some part of the process of being pregnant … and it just like definitely could be like checked in on more." "I got a lot of pressure to gain a certain amount of weight that was not necessarily realistic for me. Doctors often gave me a hard time [about gaining weight] without really exploring 'how are you really doing?', like 'are you doing really well?' … There was a lot of focus just on weight gain versus like actually like exploring, you know, deeper." "I think that doctors should explore though, if there is a person that has a history of an eating disorder, and be like, 'What do you need? Do you need anything?'