INTERNATIONAL JOURNAL OF HEALTH & MEDICAL RESEARCH

ISSN(print): 2833-213X, ISSN(online): 2833-2148

Volume 05 Issue 08 August 2026

DOI : 10.58806/ijhmr.2026.v5i8n12

Page No. 813-817

Eating Disorders in Pregnancy and Postpartum: A Narrative Review

Nuvie Oyeyemi*

Department of Obstetrics & Gynaecology, Federal Medical Centre, Yenagoa, Bayelsa State, Nigeria.

ABSTRACT

Background: Eating disorders are forms of psychiatric illnesses characterized by abnormal eating behaviours, disturbed body image, and significant physical consequences. They are among the most common psychiatric disorders in women of reproductive age. Pregnancy is usually a unique period during which there is physiological weight gain, body changes, and changing nutritional demands which may cause onset, recurrence, or aggravate eating disorders. Maternal eating disorders may lead to adverse maternal and/or fetal outcomes.

Aim: This narrative review examines the prevalence, clinical characteristics, maternal and fetal outcomes, diagnosis, and management of eating disorders during pregnancy and postpartum.

Method: A narrative review of published literature was conducted using electronic databases including PubMed, Scopus, and Google Scholar. Studies on eating disorders in pregnancy, including anorexia nervosa, bulimia nervosa, binge-eating disorder, and other specified feeding or eating disorders, were reviewed. Relevant systematic reviews, cohort studies, clinical guidelines, and expert recommendations were also included.

Results: Eating disorders may develop, persist, improve, or relapse during pregnancy. Anorexia nervosa is associated with inadequate maternal weight gain, nutritional deficiencies, fetal growth restriction, and preterm birth. Bulimia nervosa and binge-eating disorder are associated with excessive gestational weight gain, gestational diabetes mellitus, hypertensive disorders, and psychological distress in pregnancy. Diagnosis is challenging because symptoms may overlap with normal pregnancy presentations. Effective management is multidisciplinary and should involve collaboration among Obstetricians, Psychiatrists, Dietitians, Clinical Psychologists, Counselors and Mental Health Nurses.

Conclusion: Eating disorders during pregnancy require early recognition with specialized and multidisciplinary care. Routine antenatal screening, nutritional monitoring, psychological support, and individualized management are essential in optimizing maternal and fetal outcomes.

KEYWORDS: Eating disorders; pregnancy; anorexia nervosa; bulimia nervosa; binge eating; maternal mental health; fetal outcomes.

INTRODUCTION

Eating disorders are complex psychiatric conditions characterized by disturbances in eating habits and behaviour, weight regulation, and body image.[1] The major diagnostic categories include anorexia nervosa (AN), bulimia nervosa (BN), binge-eating disorder (BED), and other specified feeding or eating disorders (OSFED).[1] These disorders predominantly affect women of reproductive age, thus pregnancy is an important clinical period for onset, first recognition and management.[2]

Pregnancy causes significant physical and psychological changes, which include weight gain, altered body shape, increased nutritional requirements, and hormonal fluctuations. For women with a current or previous history of eating disorders, these changes may cause significant distress and challenge recovery. [2,3] Some women experience improvement of symptoms during pregnancy, while some others develop a recurrence or worsening of disordered eating behaviours.[3]

Eating disorders during pregnancy are often underdiagnosed. Symptoms such as nausea and vomiting, appetite changes, weight fluctuations, and altered eating patterns are usually erroneously attributed to normal pregnancy changes. Furthermore, misgivings, myths and misconceptions, shame, fear of stigma, taboo, lack of opportunity, preference for self-management and concerns regarding disclosure may prevent women from reporting symptoms.[2-4]

Depression and anxiety have been found to be associated with eating disorders in pregnancy.[5] Untreated eating disorders in pregnancy can have significant maternal and fetal consequences. Maternal complications include hypoglycaemia, nutritional deficiencies, anaemia in pregnancy, risk of osteoporosis, depression, anxiety, obesity, poor glycaemic control in diabetes mellitus in pregnancy with its attendant complications, other obstetric complications, and difficulties with breastfeeding. Fetal risks include

fetal growth restriction (FGR), low birth weight (LBW), preterm birth, congenital abnormalities associated with nutritional deficiency, fetal macrosomia, and associated neonatal complications. [2-6]
With increasing interest and awareness of maternal mental health, addressing eating disorders in pregnancy and during breastfeeding should be considered an important component of comprehensive antenatal and postnatal care.

AIM

This narrative review aims to summarize current evidence regarding eating disorders during pregnancy and postpartum, including epidemiology, clinical presentation, maternal and fetal consequences, screening, diagnosis, and management strategies.

METHOD

A narrative review of relevant literature was conducted using electronic databases including PubMed, Scopus, and Google Scholar. Search terms included combinations of eating disorders in pregnancy, anorexia nervosa, bulimia nervosa, binge eating disorder, maternal outcomes, fetal outcomes, gestational weight gain, and postnatal mental health.
Peer-reviewed studies, systematic reviews, clinical guidelines, and expert consensus publications were considered. Literature focusing on women with eating disorders during pregnancy and the postpartum period was included. Findings were synthesized narratively according to epidemiology, clinical impact, diagnosis, and management.

RESULTS

Epidemiology of Eating Disorders in Pregnancy

The prevalence of eating disorders during pregnancy is difficult to determine because many cases remain undetected, especially in low-resource settings as seen commonly in lower middle-income countries (LMIC). Estimates suggest that clinically significant eating disorder symptoms occur in a substantial proportion of pregnant women, although full diagnostic criteria are less common.[1,2,7] Approximately 5.0 -7.5% of women meet diagnostic criteria for an eating disorder in pregnancy. However meta-analyses reveal a wider prevalence range of 0.5% to 10.6% globally. There is a rising trend in the postpartum period getting up to 13%.[8-12]
Previous eating disorders may persist into pregnancy, particularly when symptoms are active before conception. Pregnancy may also represent a period of relapse for women in recovery due to anxiety related to weight gain and body changes. Also, emesis gravidarum or hyperemesis gravidarum which are conditions that occur more often in early pregnancy can lead to the development of eating disorders in pregnancy, or even aggravate existing ones.[2,8-10]

Anorexia Nervosa in Pregnancy

Anorexia nervosa is characterized by restricted food intake, intense fear of weight gain, and distorted body image. It makes up about 0.5% of pregnancies. Pregnant women with anorexia nervosa may experience insufficient gestational weight gain; suffer nutritional deficiencies, iron deficiency anaemia, electrolyte abnormalities, reduced bone mineral density and increased anxiety and depression. Maternal risks include difficulty maintaining adequate nutritional status; and obstetric risks like miscarriages, preterm birth. Fetal complications may include fetal growth restriction, small-for-gestational-age (SGA) babies, low birth weight and increased neonatal complications. Women with this eating disorder will require close monitoring of maternal weight gain, and serial fetal growth scans is essential.[10-13]

Bulimia Nervosa in Pregnancy

Bulimia nervosa involves recurrent binge eating episodes followed by compensatory behaviours such as vomiting, fasting, purging and/or excessive exercise. It occurs in close to 0.1% of early pregnancies. Pregnancy may reduce symptoms in some women, but relapse is possible. Purging behaviours can cause electrolyte disturbances, dehydration, nutritional deficiencies, dental complications and cardiac abnormalities. Bulimia nervosa has been associated with increased risks of gestational diabetes mellitus, hypertensive disorders of pregnancy, preterm birth and low birth weight babies.[9-13]

Binge-Eating Disorder

Binge-eating disorder is characterized by recurrent episodes of excessive food intake without compensatory behaviours. It affects about 1.8% of pregnancies. During pregnancy, BED is associated with excessive gestational weight gain, gestational diabetes mellitus (GDM) and other obesity-related complications, hypertensive disorders in pregnancy, and increased risk of Caesarean delivery. Psychological and psychiatric complications include increased rates of depression, anxiety, and reduced quality of life.[8-13]

Other Specified Feeding or Eating Disorders

Many pregnant women experience clinically significant eating concerns without meeting criteria for classic eating disorders. These may include restrictive eating borne from fears with myths and misconceptions about having large babies, excessive concern about weight gain, or unhealthy dietary habits and behaviours like taking a lot of caffeinated teas in the third trimester with the erroneous

belief that it reduces the weight of the baby thereby reducing the risk of fetal macrosomia.[13] This group of eating disorders affect up to 5% of women during pregnancy. Although less recognized, these conditions may still negatively affect maternal nutrition and psychological well-being.[12]

Impact on Maternal Outcomes

Eating disorders during pregnancy may contribute to poor nutritional status, excessive or inadequate gestational weight gain, anaemia in pregnancy, depression and anxiety, increased risk of obstetric interventions, lactational issues and breastfeeding difficulties, postpartum relapse. Mental health consequences are particularly important because pregnancy and the postpartum period are vulnerable periods for psychiatric illnesses like postpartum blues, depression and puerperal psychosis.

Impact on Fetal and Neonatal Outcomes

Potential fetal complications include fetal growth restriction, prematurity, low birth weight, small-for-gestational-age babies, neonatal intensive care admissions. Maternal malnutrition and altered metabolic states may influence fetal development through impaired nutrient availability and placental function.[13]

Screening and Diagnosis

Routine antenatal care provides an opportunity for identifying eating disorders. Healthcare professionals should consider screening women with significant weight concerns, abnormal gestational weight gain, previous history of eating disorders, excessive exercise behaviours, anxiety regarding body changes. Validated screening tools include Eating Disorder Examination Questionnaires (EDE-Q), SCOFF questionnaire, Eating Disorder Screen for Primary Care (ESP). A sensitive, non-judgmental approach is essential to encourage disclosure.[9-14]

Management

Management requires a multidisciplinary approach involving Obstetricians, Psychiatrists, Clinical Psychologists, Dietitians, Midwives, Mental Health Nurses, and social support services. Important components include: [14]

Nutritional management

Individualized nutritional plans should support appropriate gestational weight gain and fetal growth while avoiding reinforcement of disordered eating habits.

Psychological treatment

Evidence-based therapies include cognitive behavioural therapy, psychotherapy, and supportive counselling

Obstetric monitoring

This should include maintaining a maternal weight trajectory, a healthy nutritional status (taking an adequate maternal dietary history at every antenatal visit with subsequent non-judgmental dietary counselling), fetal growth assessment using serial growth scans, close monitoring for obstetric complications. Medication decisions should closely consider severity of psychiatric symptoms and the safety of the fetus.

DISCUSSION

Eating disorders during pregnancy represent a complex interaction between psychiatric illness, nutritional health, and obstetric care. Although pregnancy may improve symptoms in some women, others experience significant distress related to body changes and weight gain.[1,2,15]

The under-recognition of eating disorders remains a major challenge. Many healthcare providers focus primarily on excessive weight gain or inadequate weight gain without exploring underlying psychological factors. Routine screening for eating concerns could improve early identification.[16-19]

Management should avoid judgmental and stigmatizing approaches that focus exclusively on weight. Instead, care should emphasize maternal nutritional adequacy, psychological well-being, and healthy fetal development.[15-19]

The postpartum period requires continued attention because women may experience recurrence of symptoms, difficulties with body image, depression, and challenges related to breastfeeding and infant feeding.[11,18-22]

Future research should focus on standardized screening strategies, long-term maternal outcomes, and effective interventions specifically designed for pregnant women with eating disorders.

CONCLUSION

Eating disorders during pregnancy are important but frequently overlooked conditions that can adversely affect maternal and fetal health. Anorexia nervosa, bulimia nervosa, and binge-eating disorder are associated with nutritional, obstetric, psychological, fetal and neonatal complications. Early identification through sensitive screening and coordinated multidisciplinary management is essential. Pregnancy care should incorporate mental health assessment alongside routine obstetric monitoring to support optimal outcomes for mothers and their infants.

ABBREVIATIONS

AN – Anorexia nervosa
BED – Binge-eating disorder
BN – Bulimia nervosa
C/S – Caesarean section
EDE-Q – Eating disorder examination questionnaire
ESP – Eating disorder screen for primary care
FGR – Fetal growth restriction
GDM – Gestational Diabetes Mellitus
LBW – Low birth weight
LMIC – Lower middle-income countries
OSFED – Other specified feeding or eating disorders
SCOFF – Sick, Control, One, Fat, Food
SGA – Small-for-gestational-age

REFERENCES

1) American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th ed. Washington DC: APA; 2013.
2) Micali N, Treasure J, Simonoff E. Eating disorders symptoms in pregnancy: A longitudinal study of women with recent and past eating disorders and obesity. *Journal of Psychosomatic Research.* 2007;63(3):297-303. ISSN 0022-3999. https://doi.org/10.1016/j.jpsychores.2007.05.003
3) Bye A, Nath S, Ryan F, et al. Prevalence and clinical characterization of pregnant women with eating disorders. *European Eating Disorders Review.* Jan 2020; 28(2):141-155. Doi: 10.1002/erv.2719
4) Bye A, Shawe J, Bick D, Easter A, Kash-Macdonald M, Micali N. Barriers to identifying eating disorders in pregnancy and in the postnatal period: a qualitative approach. *BMC Pregnancy and Childbirth* (2018) 18:114, https://doi.org/10.1186/s12884-018-1745-x
5) Easter A, Solmi F, Bye A, et al. Antenatal and postnatal psychopathology among women with current and past eating disorders: Longitudinal Patterns. *Eur Eat Disord Rev.* 2014 Oct 26;23(1):19-27.doi:10.1002/erv.2328.
6) Watson HJ, Jangmo A, Smith T, et al. A population-based study of eating disorders during pregnancy. *Int J Eat Disord.* 2019;52(11):1215-1225.
7) Micali N, De Stavola BL, Ploubidis GB, et al. Maternal eating disorders and pregnancy outcomes. *Am J Clin Nutr.* 2016;104(2):386-394.
8) Linna MS, Raevuori A, Haukka J, et al. Pregnancy, delivery and perinatal health outcomes in eating disorders. *Int J Eat Disord.* 2014;47(1):27-35.
9) Solmi F, Sallis H, Stahl D, et al. Low birth weight and eating disorders. *Psychol Med.* 2021;51(10):1708-1717.
10) Blais MA, Becker AE, Burwell RA, et al. Pregnancy: outcome and eating disorders. *Int J Eat Disord.* 2015;48(7):927-935.
11) Torgersen L, Ystrom E, Haugen M, et al. Breastfeeding and eating disorders. *Int J Eat Disord.* 2010;43(2):108-116.
12) Cicekoglu Ozturk, P., Tastekin Ouyaba, A. Prevalence and related factors of eating disorders in pregnancy: a systematic review and meta-analysis. *Arch Gynecol Obstet* 309, 397-411 (2024). https://doi.org/10.1007/s00404-023-07051-3
13) Easter A, Naumann U, Northstone K, et al. Associations between maternal eating disorders and child outcomes. *J Child Psychol Psychiatry.* 2014;55(8):889-898.
14) National Institute for Health and Care Excellence. Eating disorders: recognition and treatment. NICE guideline NG69. London: NICE; 2017.
15) Bye A, Shawe J, Baird J, et al. Pregnancy and eating disorders: a systematic review. *Nutrients.* 2018;10(11):1562.
16) Barthels F, Meyer F, Pietrowsky R. Dieting and eating disorders during pregnancy. *Nutrients.* 2018;10(8):1075.
17) Bulik CM, Sullivan PF, Fear JL, Pickering A. Outcome of pregnancy in women with eating disorders. *Int J Eat Disord.* 2000;27(3):263-269.
18) Koubaa S, Hallström T, Lindholm C, Hirschberg AL. Pregnancy and eating disorders: postpartum outcomes. *Eur Eat Disord Rev.* 2015;23(6):427-434.
19) American College of Obstetricians and Gynecologists. Screening and diagnosis of mental health conditions during pregnancy and postpartum. *Obstet Gynecol.* 2023;141(6):1232-1261.
20) World Health Organization. WHO recommendations on maternal and newborn care for a positive postnatal experience. Geneva: WHO; 2022.
21) Micali N, Treasure J. Biological and psychological factors in eating disorders during pregnancy. *Lancet Psychiatry.* 2023;10(2):124-136.

22) Himmerich H, Kan C, Au K, Treasure J. Pharmacological treatment of eating disorders and considerations during pregnancy. *Expert Opin Pharmacother.* 2022;23(6):711-723.