THE MANAGEMENT OF EATING DISORDERS IN A FERTILITY CLINIC : CLINICAL GUIDELINES

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Abstract

Although child wish may be ambivalent in women with anorexia or bulimia nervosa, the prevalence of eating disorders in fertility clinics is probably underestimated. Motivated by the wish for a child these couples may be reluctant to reveal a history of an eating disorder and/or show resistance to some therapy for this disorder. Nevertheless, in our opinion the eating disorder must be in full remission before any fertility treatment can start, if still necessary at that moment. Illustrated with some case examples, we will discuss the major problems and clinical strategies in the management of these complex cases based upon the experience in our own fertility clinic.

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Eating disorders and infertility

In the scientific literature little attention has been paid to the link between fertility problems and eating disorders (ED) such as anorexia nervosa (AN) and bulimia nervosa (BN). Two survey studies found a higher prevalence of eating disorders in women visiting a fertility clinic compared to a population of young women (Stewart et al., 1990; Thommen et al., 1995). The fertility problems in ED women may be due to various factors.

Hormonal disturbances are quite common in ED. While amenorrhoea is a part of the clinical characteristics of AN, at least 50% of BN women at normal weight suffer from amenorrhoea or oligomenorrhea, generally associated with impaired follicular maturation due to reduced LH concentrations and pulse frequency. When weight restoration in AN or weight stabilisation in BN does not lead to normal menstrual function, it reflects a nutritional imbalance due to unhealthy eating habits, persisting dieting or other anorectic behaviours such as food restriction, purging or excessive physical activities (Abraham & Llewellyn-Jones, 1995; Copeland, Sacks & Herzog, 1995). Clinicians are not always aware, like some patients, that the use of oral contraceptives by sexually active ED women camouflages this hormonal disturbance. A recent study showed various shortcomings in the knowledge of gynaecologists about eating disorders (Morgan, 1999).

Another cause of fertility problems is the Polycystic Ovarian Syndrome (PCOS). McCluskey et al. (1992) found an association in two directions between PCOS and ED: 75% of BN women had PCOS, while 33% of women with PCOS reported bulimic eating behaviour. Hence, women with PCOS should also be routinely screened for abnormal eating behaviour (Morgan, 1999).

A psychological reason for infertility may be found in the sexual problems of ED women. The few studies involving adult women with restricting AN (Haimes & Katz, 1988; Heavy et al., 1989; Raboch & Faltus, 1991; Tuiten et al., 1993) revealed several problems: generally speaking, AN women are slower in their sexual development and report more sexual problems and dissatisfaction. The only study involving adult BN patients (Jagstaidt & Pasini, 1994) suggest a similarity in sexual activity with normal controls, but a higher frequency of sexual dysfunctions or dissatisfaction inhibiting regular sexual activities within the marital relationship.

Finally, the fertility problems in these women may reflect their personal ambivalence towards the responsibility of the care for children. Many ED patients regard the absence of menses as a comfortable status. As long as there is no child wish, they will seldom consult a gynaecologist. As such the eating disorder may "protect" them from getting pregnant and being confronted with some psychological threats related to a pregnancy: the uncontrollable bodily changes, the impact on the marital relationship, the responsibility of the education of a child.

Eating disorders and pregnancy

Regardless of a history of an ED, these adult women could have the desire for a child. In this regard, we may note that about one-third of the married anorectics have children (Brinch et al., 1988; Woodside et al., 1993). Confronted with hormonal disturbances, they will ask for fertility treatment instead of asking for treatment for their eating disorder. In general it is known that these women do not inform their gynaecologist or obstetrician about their past or present ED history (Stewart et al., 1990; Franko & Walton, 1993; Hall, 1996; Franko & Spurell, 2000). What are the risk of pregnancy in ED women?

Women who conceive during the active phase of their ED show an increase of anxiety and depression. Their fear of losing control over their weight may result in preventing weight gain by dieting or other means such as vomiting. It is important to distinguish this behaviour from pure Hyperemesis Gravidarum, and its association with an ED should be considered when there is a failure to gain weight during pregnancy (Lingam & McCluskey, 1996).

Although some studies found a remission of the ED symptoms during pregnancy, there is only a small group of ED women (23%) in whom this favourable evolution is lasting after childbirth (Lemberg, Phillips & Fisher, 1992) while in others the ED symptoms would even worsen in comparison with the pre-pregnancy period (Morgan, Lacey & Sedwick, 1999). If women become pregnant with a low body weight, or continue dieting, bingeing or purgeing during pregnancy, they have a higher risk of miscarriages, low-weight newborns and are more prone to deliver infants with birth defects (Abraham, 1998b; Abraham & Llewellyn-Jones, 1995; Conti, Abraham & Taylor, 1998, Franko & Spurrell, 2000).

After delivery, the prevalence of postnatal depression is greater in ED women (Abraham, 1998b; Morgan, Lacey & Sedwick, 1999). The parenting is affected by the disruptive impact of the ED symptoms on daily functioning of these women: not only feeding

behaviour, but also play interactions are contaminated by the psychological side-effects of the ED (Stein, 1995; Stein & Woolley, 1996; Waugh & Bulik, 1999).

An aspect which merits further attention is the mediating role of the quality of the marital relationship in the effect of the pregnancy on the ED. According to some studies (Lewis & le Grange, 1994; Woodside et al., 1993) women whose ED recovered completely during pregnancy, tended to have a stable and meaningful marital relationship, whereas those who did not show a favourable evolution have serious interpersonal problems.

All these clinical and research findings point out that a pregnancy in combination with an ED may jeopardize maternal and foetal health. Therefore we feel justified to conclude that a pregnancy, and hence any fertility treatment, is contra-indicated when an anorectic or bulimic woman is still showing the core symptoms of an ED. In our opinion pregnancy and fertility treatment can only be taken in consideration when there is a clear remission of the ED. In the following paragraphs we will discuss the implications of this conclusion in our own fertility clinic.

Clinical implications

The basic rule in our fertility clinic is that women with an ED should get psychological help before becoming pregnant. This implies the detection of an eating disorder by the clinician, while many of these women are used to hide their disturbed eating pattern for the outside world. The clinical characteristics are described in the diagnostic criteria of the DSM-IV (American Psychiatric Association, 1994; see Table 1). Just checking the patient's body weight is not enough, certainly not since in BN the weight is often (close to) normal. As mentioned in the diagnostic criteria the crucial characteristics are the eating behaviour and the attitudes towards food, weight and shape.

insert Table 1 about here

We can expect couples in fertility treatment to be reluctant to consult the psychologist or counselor in the fertility centre (Boivin et. al., 1999). This is specially true for ED women, because of their tendency to deny or minimize the problems and/or because of their ambivalence to accept treatment for their ED. In our clinic, when there are clear signs or a serious suspicion of an ED, the couple is referred to the psychologist of the team (J.N.) for

further exploration. Contrary to Abraham's opinion (1998), in our experience several of these women do not easily accept this referral as the next step in their treatment process. Therefore, we are confronted with different emotional reactions in these women and their partner.

First, some couples do not accept the referral to a psychologist. Hence they quit and it may be assumed that they visit another fertility clinic with the hope they will be accepted there for fertility treatment without psychological screening.

The second reaction is one of astonishment. They accept the referral and they present themselves with an attitude to convince the psychologist they are "healthy" persons. They do not accept the reality of a serious psychological problem. They are so used to their lifestyle, they cannot understand that this could be the cause of the fertility problems. For them it is so "normal" to control their food intake, do intensive sports and watch their body weight. For years they are taking contraceptive pills not realising this could be a camouflage for their eating disorder. Some confess they had an anorectic period during puberty but everything seems normal in their present life, so they cannot understand why this psychological screening is necessary.

The third reaction is they agree they have a problem, but the desire for a child is so overwhelming that this will help them to get rid of the eating disorder. Hence, they are insisting to continue fertility treatment.

> Ellen is a 30-year-old woman who since her marriage, three years ago, has a strong wish for a child. But she weighed 44 kg and had amenorrhoea for five years. Since her puberty she was obsessed with food and weight, and spent a lot of time exercising. She could not accept her infertility and on lonely evenings she started bingeing and vomiting. Although another gynaecologist suggested a link between her weight and her unfulfilled child wish, she refused this hypothesis and continued her anorectic way of life. She then came to our fertility clinic. At the end of her first psychological consultation she asked for a quick start of the fertility treatment.

A fourth possibility is that we are confronted with ED women who slipped through the diagnostic phase and start fertility treatment. After several failed trials they confess to the gynaecologist (and often for the first time to their husband!) the presence of an ED. They feel guilty that the ED is the cause of the treatment failure. Now they are willing to accept psychotherapy for their ED and postpone the fertility treatment until they are recovered.

> After six in vitro fertilisation treatments without conception, Sarah confessed to her husband and her gynaecologist she has binged and vomited for at least six years. She had hidden this problem during her 7-years-old marriage to keep for herself the picture of a happy marriage. She was convinced her husband would be very disappointed because he did all the time his best to make her life as pleasant and comfortable as possible after a unhappy youth, caused by the divorce of her parents.

In these cases there is often a problem within the relationship. These men are shocked about the reality of being fooled for several years and now their idea of a happy marriage has collapsed. These husbands are not always willing to participate in the psychotherapeutic process of their wives. Their resistance or even undermining attitude could strongly influence the course and outcome of the therapy (Van den Broucke, Vandereycken & Norré, 1997).

The pivotal point in this process is the switch from a medical treatment towards a psychological one. It's the task of the psychotherapist to guide the couple through this process. The basic therapeutic attitude is one of respect with recognition of their desire for a child. To enhance the motivation we use different strategies (see Van den Broucke et al., 1997). The meaning of a child in their personal life and the way they deal with this theme within the relationship should be analysed considering the possible link with the ED.

> Laura had always had a strong desire for a child. After four years of marriage she and her husband decided they were ready for it. After six months without conception they visited a gynaecologist, who found an azoospermia (absence of sperm cells). This was a shock for both but especially for Laura. She became depressed, started to diet and lost twenty pounds in three months. Then she switched to bingeing and purging. At the first meeting in the fertility clinic the husband realised his wife always complained about her weight and shape. Now they have to face the fact that beside his physical problem her ED causes extra fertility problems. In terms of fertility treatment, donor insemination appears to be the only alternative.

In such a case we ask the couple to imagine and write down a future life story of being a mother with an ED. Instead of a sweet dream, we ask them to imagine as realisticly as possible a picture of their relationship having a baby. This story can be analysed with the

couple in terms of advantages and disadvantages. Then we inform them about the findings of existing research on pregnancy, parenting and eating disorders. It is important these data are brought with sufficient knowledge and clarity to make it meaningful for the couple (Vitousek & Watson, 1998).

The husband's attitude can play a stimulating role towards his wife in order to first address the ED before getting pregnant. It depends on the way they cope with emotional problems within their relationship whether this will result in a constructive conflict. It might be the first time he is openly choosing the confrontation instead of searching for a compromise with the ED of his wife. Finally, the husband can show his personal commitment by playing an active role in the treatment of her ED (see Van den Broucke et al., 1997).

> Laura was restoring her weight and building up a healthy eating pattern, but she realised she could not accept her husband's anger towards herself. Until now, she didn't dare to talk about this with him, because she had always seen him as a successful manager in his professional life. Confronted with the fertility problems, she did not want such an angry father for her child. She agreed to discuss this theme in the couple therapy.

Conclusion

The presence of an active or unsufficiently remitted ED is, in our opinion, a contra-indication for a pregnancy and hence for any fertility treatment. Such a treatment would reinforce the denial or minimization of the ED and enhance the ambiguity between the demand of a woman to get pregnant and her body telling she is not ready for it. Therefore, these patients should be treated first for their ED before becoming pregnant. Once they have overcome the ED, the experience of a healthy pregnancy and childbirth can become a most rewarding life-event.

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Table 1. Diagnostic criteria for eating disorders according to DSM-IV

Anorexia Nervosa

A. Refusal to maintain body weight at or above a minimally normal weight for age and height (less than 85% of expected weight).
B. Intense fear of gaining weight or becoming fat, even though underweight.
C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.
D. In postmenarcheal women, amenorrhoea, i.e. the abscence of at least three consecutive menstrual cycles.

Subtypes :

Restricting type : during the current episode of anorexia nervosa, the person has not regularly engaged in binge-eating or purging behaviour.

Binge-eating/Purging type: during the current episode of anorexia nervosa, the person has regularly engaged in binge-eating or purging behaviour.

Bulimia Nervosa

A. Recurrent episodes of binge eating, characterized by :
    - eating, in a discrete period of time, an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances
    - a sense of lack of control over eating during this episode.
B. Recurrent inappropriate compensatory behaviour in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.
C. The binge eating and inappropriate compensatory behaviours both occur, on average, at least twice a week for three moths.
D. Self-evaluation is unduly influenced by body shape and weight.
E. The disturbance does not occur exclusively during periods of anorexia nervosa.

Subtype :

Purging type: during the current episode of bulimia nervosa, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas

Nonpurging type: during the current episode of bulimia nervosa, the person has used other inappropriate compensatory behaviours, such as fasting or excessive exercise.

Current knowledge on this subject

- One of the physical consequences of an eating disorder is reduced fertility in these women.
- A pregnancy in combination with an eating disorder may jeopardize maternal and foetal health.
- Women with an eating disorder do not inform their gynaecologists about this problem.

What this clinical report adds

- Improved awareness is necessary in health professionals working in a fertility clinic
- Management and motivational strategies for these women to engage in psychotherapy for their eating disorder instead of a fertility treatment for their child wish

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Introduction

One of the medical consequences of an eating disorder could be reduced fertility capacities. Ignoring this reality, these women could use fertility clinics to fullfill there childwish. In this article we discuss the consequences of this reality and we propose strategies to motivate this women together with their partner to work on the eating disorder before becoming pregnant.

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