Eating Disorders and Fertility

Practicum in Health Promotion at the Multiservice Eating Disorder Association (MEDA)

*Newton, MA*

Final Paper ID 264

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Due Date: May 11th, 2012 8:30am

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Abstract

Objective: To address the unmet need for educational and empowering support groups for women struggling with eating disorders and fertility issues (infertility or pregnancy).

Design: Creation of two support group curricula, corresponding websites, pre- and post-course surveys and advertisement fliers.

Materials and Methods: A literature review was performed to characterize the target populations’ needs and identify interventions with the best chance of success. Curricula and handouts from prior MEDA support groups were studied. Relevant texts and blogs on body image, cognitive behavioral therapy, interventions and self-help books on eating disorders were reviewed. This information harnessed to develop curricula for two private support groups, session-specific handouts, fliers to advertise the groups and facilitate enrollment and pre- and post-course surveys to address the needs of participants and evaluate program efficacy. Additionally, comprehensive websites where participants could receive streamlined, MEDA-approved information and support were designed to supplement each course.

Results: Literature review revealed paucity in blogs, support groups and interventions devoted to eating disorders among women who are pregnant women, post-partum or trying to conceive. Primary literature review and past MEDA support group curricula reveal that principles of CBT, body image and group-based support have been successfully integrated in interventions with this demographic.

Two courses “Fertility and Female Empowerment” and “Pregnancy and Female Empowerment” were created, incorporating components of education, discussion and skill-building exercises and emphasizing a gendered perspective, media literacy and assertiveness. Websites expanded curricula, offering readily accessible media and literature to quell urges. Fliers were created to advertise and pre- and post-course surveys were written. Curricula, websites, fliers and surveys were reviewed with professionals in the field and informally pilot-tested.

Conclusion: The project addresses the need for a supportive and empowering health-based support group for women struggling with infertility or pregnancy in addition to an eating disorder. This project promises insight into the poorly understood and complex issue of eating disorders and fertility and will provide insight into how to support these daughters, wives and mothers.
I. Introduction

There is an unmet need for educational and empowering support groups for reproductive-age women struggling with pregnancy or sterility in concert with their eating disorders. Specifically, there exists a lack of psychotherapy techniques, including support groups, dedicated to women who are pregnant or seeking conception while working toward and in recovery from eating disorders. In the field of reproductive health, studies have documented increased risks in the eating disorder community of obstetrical and gynecological complications ranging from an increased risk of mental illnesses while pregnant to infertility.\textsuperscript{7,9-14} These fertility complications threaten to trigger relapse by re-igniting insecurities of self-worth, self-respect and body image. Despite a demonstrated increased need for therapy, there exists at the same time a paucity of academic literature investigating the success of interventions specific to women struggling with eating disorders and pregnancy or infertility.\textsuperscript{17-19}

The percentage of our nation’s boys and girls struggling with eating disorders (binge eating disorders and bulimia) is increasing.\textsuperscript{21} Currently, eating disorders are the third leading cause of chronic illness in adolescent girls in the United States.\textsuperscript{8} Though myriad social and cultural factors are responsible for this increase, two forces are particularly alarming: the perseverance of unrealistic ideals (glorification of unrealistic thinness in females and extreme, near-Herculean muscularity in males) and the ease with which large quantities of high-fat, calorie-dense food can be purchased and consumed in today’s society. Though statistics in this demographic are notoriously lacking, extrapolating from the general population, it follows that the number of women struggling with eating disorders while shouldering burdens of fertility or sterility (trying
to conceive, dealing with pregnancy or the postpartum period) is also only rising.\textsuperscript{3,6-8} My project addresses a taboo subject that’s rarely addressed and poorly understood. This project promises insight into what is a growing and largely unaddressed health problem and further, may also provide insight into how to support these daughters, wives and mothers.

MEDA’s mission is to prevent and treat eating disorders and disordered eating through educational workshops and early detection. Further, they serve as a support network and resource for clients, loved ones, clinicians, educators and the public. Specific to the scope of MEDA’s mission, this project will meet the aforementioned unmet need for a supportive yet structured program that is dedicated to the recovery of women with eating disorders who are struggling with issues of fertility.

Methodology

To effectively implement this project, I researched the subject of eating disorders as well as methods of addressing the subject in psychotherapy and media (online) campaigns. Unfortunately, a literature review was completely inconclusive: there are no peer-reviewed journal articles detailing interventions specific to the theme of fertility and/or pregnancy in the eating disorder population. I confirmed this surprising finding during a meeting with an expert in the field of eating disorders, behavior and psychiatry: Dr. Nadia Mikali.\textsuperscript{31} Turning to the internet, I scoured websites for support groups and blogs. To gain a better sense of what women will want out of the support group and what issues are relevant in the eating disorder community, I read pro-ana and pro-mia blogs.\textsuperscript{15-16, 22} I even found a pro-ana blog dedicated to weight loss after pregnancy.\textsuperscript{16} What ended up being the most useful were blogs written by women in
recovery who detailed how pregnancy or the process of undergoing assisted reproductive technologies techniques provided unique challenges and emotional hurdles. 

Texts on group psychotherapy for the Eating Disorder population as well as educational information from MEDA, ranging from brochures and informational packets on Eating Disorders to conversations with staff were endlessly helpful. At my practicum director’s suggestion, I read two self-help books that are popular among MEDA support groups attendees (Living With Ed, Goodbye Ed, Hello Me by Jenni Schaefer). Also of great usefulness were studying curricula from previous MEDA support groups. To collect additional information, I attended a bulimia support group at MEDA to get ideas and a better sense for how the group meetings are run. As will be shared in my personal reflections, this experience was exceedingly valuable, not only to the development of curricula but also to my personal development.

In evaluating how other groups in the community addressed this issue, I came across a similar group in Newport Beach, California. This group focused on an issue they termed “Pregorexia” and holds weekly meetings for Moms with eating disorders and pregnant women with eating disorders. The interests and objectives of this group are to discuss the impact of an eating disorder on pregnant women (and their babies) and how mothers who already have children can work towards eating disorder recovery to achieve healthy family relationships. This group focuses more on achieving healthy family dynamics and focuses less on empowering the individual female. It also fails to address the demographic of women struggling with an eating disorder and infertility, or while attempting to conceive. Lastly, after time researching this population of women and working to understand their struggles, I was offended by the use of “pregorexia”, a trite
and catchy term that minimizes the formidable journey that is recovery, not to mention enduring childbearing, childbirth and the post-partum period while remaining in recovery. However, I found the group setting seemed the ideal forum to facilitate support; it reminded me of the model of “Centering Pregnancy” in which comprehensive and well-woman healthcare to expecting mothers is coordinated such that women of similar gestational age and their partners join a group that meets throughout pregnancy and the post-partum period. Nurse creator Sharon Schindler has seen much success with the model, in which women receive assessment, education and support in a comforting environment that allays fears, shares concerns and burdens and prepares expectant mothers to be better-equipped for the happy challenges of pregnancy and motherhood.33

Believing the group approach to be best, together with MEDA staff I determined the best approach would be to create two closed (private, not open to the public) support groups (Pregnancy and Fertility). Closed groups are preferable to open groups in instances like this, in which we will have a structured curriculum with set goals to accomplish, lessons to teach and ground to cover at each session. Two groups were thought to be preferable to one so that we could offer a safe, comfortable space for women to speak. It was our concern that if we merged the groups, we could create tension in situations where some women are desperately working to become pregnant and others are continuing to struggling to accept/keep/be happy about a current or recent pregnancy. Further, we discussed what to include in each of the meetings of the support groups, deciding the ideal combination would consist of education information on pregnancy or fertility, facilitated discussion and skill-building exercises. Further, we chose to implement our project, drawing on a pillar of the “Current Innovations Model”,}
such that selected support group facilitators will be role models who could relate to the participants’ struggles and recovery. The facilitator to the support groups will be a woman who is not only a former nurse with medical knowledge, but she is also in recovery from an eating disorder and had a child through in vitro fertilization. Because participants can imagine being in the shoes of the role model (and the role model being in their shoes), participants will be made to feel more comfortable sharing in discussions.

Findings

The intersection of motherhood, fertility and evolving body image in reproductive-age women is a theme that remains poorly addressed by interventions in the United States and the United Kingdom. Literature review revealed paucity in interventions despite a suspected rise in eating disorders among women who are pregnant, recently pregnant or trying to become pregnant. There is not a single peer-reviewed journal article detailing an intervention geared toward this population of women. Yet there is demonstrated need.

Women with or in recovery from restrictive eating disorders appear to experience lifelong lower fertility rates and higher rates of pregnancy complications. Research shows that in severe restrictive eating disorders, up to ¼ of patients never regain normal menstruation cycles even after treatment. At the same time, if women become seek fertility treatments before they have recovered from severe restricting behaviors, they have lower rates of success. If these women do become pregnant, studies suggest they may face a higher risk of complications like miscarriage, birth defects and low birth weight babies, Cesarean section, and postpartum depression. Fertility is known to be related to eating disorders such that one affects the other and vice versa.
Restricting, binging and purging eating disorders can negatively impact fertility. At the same time, addressing infertility or a pregnancy is a stressful and anxiety-provoking, often triggering urges to resort to restricting or purging behaviors. Any relapse is serious, as anorexia nervosa is the psychiatric diagnosis in the DSM-IV associated with the highest rate of suicide.\textsuperscript{21}

There are a number of documented approaches to addressing the issue of eating disorders in women. The first is dealing with the issue on an individual level. This intervention is not only the most costly, but also is contingent on a referral or self-presentation to medical attention. This intervention is predicated upon referral to a therapist, which often occurs after speaking with an obstetrician, primary care doctor or fertility doctor. Although there is a high utilization of medical care in the eating disorder population, studies show that most healthcare professionals may only detect an eating disorder once substantial medical and psychological consequences have developed.\textsuperscript{1,2} Studies show that Obstetrician-Gynecologists are not confident in their ability to diagnose disorders of eating and feel they are inadequately prepared to handle such issues.\textsuperscript{3} Perhaps most importantly, studies show that patients with eating disorders are embarrassed about their condition and fear judgment from health professionals.\textsuperscript{4} Often, busy practitioners try to avoid conversations of this type or, when addressed, may minimize or intellectualize the issue (e.g. physician remarks that the woman is not underweight or is gaining appropriately at this stage in pregnancy). Ideally, women who present to medical attention in this way would be referred to more comprehensive treatment and care centers, such as MEDA.
Another approach to this issue has been media online campaigns. The existence of pro-anorexia (pro-ana) and pro-bulimia (pro-mia) blogs is both a pro and con to the approach of an online media campaign. On the one hand, women reading negative blogs (encouraging disordered eating) would benefit from positive blogs that offer reassurance, support and information about seeking help. Further, studies show internet-based services are well-accepted among the target eating disorder community. Another study shows promising results in reducing risk for relapse in patients recovering from eating disorders. On the other hand, the persistence of pro-ana and pro-mia sites is evidence to the fact that, though these women are participating in a social connection, they remain unable to participate in the sense of community that comes with group meetings. Websites can also contain inaccurate information that could upset, frighten or trigger women’s issues.

A happy medium between these two interventions exists in the form of treatment groups led by therapy specialists that can guide discussion and interaction to focus on meeting the emotional needs of the group while reinforcing the most empowering and useful concepts. Group psychotherapy, in both psychoeducational formats and interpersonal-oriented therapy, has been shown to be as successful as intensive, individualized therapy. As aforementioned, no primary literature exists to guide future interventions.

Research on this population revealed the need for support groups addressing issues of fertility in reproductive-age women in recovery from eating disorders. I developed two courses (“Fertility and Female Empowerment” and “Pregnancy and Female Empowerment”). Each course has 8 weekly sessions, each of which contains
educational aspects (e.g. What factors influence ovulation? What are the benefits of breastfeeding?), skill-building exercises (e.g. How to negotiate fertility treatments with your doctor; how to firmly tell a stranger to quit rubbing your belly!) as well as discussion questions (e.g. Does thinking about pregnancy trigger other anxious thoughts? Most pregnant women share concerns about their delivery, finances, body image or marriage. What concerns do you have?).

Webpages containing the full curriculum for the “Pregnancy and Female Empowerment” as well as the “Fertility and Female Empowerment” courses are included in Appendix I. Further, an example curricula from one session of each class is included in Appendix II. Lastly, flyers to advertise and recruit subjects for each course (see Appendix III).

Program evaluation will be achieved through pre- and post-course surveys as well as continually elicited feedback at group meetings and on every page of the website. The goal of these evaluations is to gain a sense for the merits of the course, to identify any unmet needs or emergent new needs. The survey (Appendix IV) contains both qualitative and quantitative data, evaluating the utility of the group, the appropriateness of time devoted to the topic, and the impact of the course. The survey also evaluates the various elements of the course (skill-building exercises, educational handouts, Google Site). Participants will select their favorite session/topic and their least favorite topic and will be encouraged to provide additional, detailed feedback on what worked well and what didn’t. They will specifically be asked what topics were insufficiently covered or altogether not addressed. The surveys are for MEDA internal purposes only; they will remain 100% anonymous and responses will not be marked or tracked in any way unless
respondents provide their email address to be contacted for additional feedback. Session-specific feedback will be elicited via the webpages and during or after individual support group meetings. Further, feedback was integrated into the websites such that it is elicited after every session and on every page of the site.

Conclusions

Research shows that support groups for reproductive age women in recovery from eating disorders who are struggling with acceptance of pregnancy or infertility are few. At the same time, studies suggest the need to address this demographic is only growing.15-16,22 As aforementioned, the issues of eating disorders and fertility are known to be interrelated such that one affects the other and vice versa. The risks of inaction are dire, as anorexia nervosa is the psychiatric diagnosis in the DSM-IV associated with the highest rate of suicide.21

This project addresses the unmet need for supportive and empowering health-based support groups for women struggling with infertility or pregnancy in addition to an eating disorder. This project promises greater understanding of the complex issue of eating disorders and fertility, allows for better characterization of this understudied and poorly understood public health problem and offers insight into how to support these daughters, wives and mothers.

At this practice placement, I employed skills of performing literature searches for academic studies on successful interventions in this population; I combined information from academic literature with information from internet searches and blog sites. I studied successful psychotherapy interventions to learn more about the support and care for those battling eating disorders. I researched well-studied and effective exercises to build
emotional expression skills, emotional coping skills, and conduct assertiveness trainings. I re-examined medical literature on healthy pregnancies (nutrition, weight gain, exercise, labor course) and healthy habits for all women of reproductive age (alcohol use, exercise, nutrition). For the first time, I will utilize skills in social media, media advertising, and health communication in the creation of two webpages. I also learned community-based research skills through the creation of surveys evaluating the program on the pillars of knowledge/attitudes+beliefs/behaviors.\textsuperscript{32} I utilized these new skills to combine teachings from the medical literature, discussion and skill-building to create an empowering, relatable and comprehensive learning experience.
Appendix I. Course Websites

Fertility and Female Empowerment:
https://sites.google.com/site/medafemaleempowerment/

Pregnancy and Female Empowerment:
https://sites.google.com/site/medapregfemaleempowerment/

Appendix IIa. Curricula Example: Fertility Course, Session #3
What Affects Fertility?

“Whatever women do they must do twice as well as men to be thought half as good. Luckily, this is not difficult.” – Charlotte Whitton

Pre-class question: If you were a type of weather, what weather are you today?

Causes of female infertility

- Ovulatory disorders = The egg is not ovulated because there aren’t enough eggs or because the hormones signaling ovulation are dysregulated
  - Can be due to: advanced maternal age, premature ovarian failure (similar to menopause), undereating, overexercising
- Tubal Infertility (fallopian tube abnormalities) = The ovulated egg is unable to get to the uterus.
  - Due to: pelvic surgery, endometriosis, untreated chlamydial or gonorrheal infection
- Less commonly:
  - Uterine abnormalities = an unaccommodating, abnormally-shaped uterus
  - Cervical abnormalities = chronic inflammation, cervical incompetence

[Diagram of female reproductive system]

Causes of male infertility (“male factor”)

- Not enough sperm = Oligospermia, low sperm count
- Abnormal sperm = Asthenozoospermia, sperm can’t swim to egg
- Inaccessible sperm= due to an untreated mumps infection or vasectomy

Infertility as a Life Stressor

Infertility is a stressor that is not only stressful in its own right but can act to amplify problems in other realms of your life (relationships, finances, sense of self-worth). It is critical to your well-being as an empowered female, and to your personal development as a future momma bear, to be able to articulate life stressors and express complex emotions. Additionally, researchers like Dr. Alice Domar have done excellent work characterizing the positive fertility benefit of reducing life stressors. Be sure to check out her mind-body-health blog (link below)!

Discussion: Does thinking about infertility trigger any anxious thoughts?

Recall Last week’s Emotional Expression Lessons: Try to be an observer to these thoughts; identify them and trace back the source of the anxiety. (e.g. Does facing a potential diagnosis or subfertility or infertility trigger issues with body image? Family? Money?)

Emotional Expression Skills (EES), continued

-Utilizing Your Support System
  - Talking about your feelings or thoughts with an understanding person
  - Talking to a therapist or counselor
  - Arranging not to be alone
  - Going to a support group
  - Spending time with a pet
- Spending time with a person you enjoy
- Planned activities with a caring and supportive person

*see the Google Site for more information on EES*

**Introduction to Assertiveness Training:** Assemble into groups of 3

**Scenario: Conversation with coworkers (roles: female, coworker #1, coworker #2)**

Imagine a coworker comes up to you and says “Are you still trying to get pregnant? You shouldn’t have waited so long to start trying. My sister waited too long and now all her eggs are gone. Do you have any left? Do you even know? What are you doing to try to get pregnant?” Act out how you would respond to this person in an assertive way you can be proud of (and that even decreases the chance that they approach you with such invasive, inappropriate comments in the future!).

After you assert yourself to coworker #1, imagine coworker #2 joins in with “we were only asking because we care about you. If you want us to not speak to you, we can leave you alone.” Respond to this passive-aggressive comment from coworker #2 with an assertion that communicates your desire to have an appropriate, mutually respectful working relationship.

**Exercise At-Home:** Practice asserting yourself to someone who doesn’t know you have a history of an eating disorder (obstetrician, primary care physician, spouse, etc…)

**References**

http://www.fertilethoughts.com/
Appendix IIb. Curricula Example: Pregnancy Course, Session #2

The Obligation of Pregnancy
“A woman is the full circle. Within her is the power to create, nurture and transform.” ~ Diane Mariechild

Emotional Expression Skills = a learned life skill that eases emotional regulation

http://medical-dictionary.thefreedictionary.com/pregnancy

The Gender-Specific Burden of Pregnancy
Though it is women’s biologically-driven responsibility to bear the most cumbersome burdens of reproduction (e.g. pregnancy and childbirth), gender experts argue that social norms place a disproportionate responsibility on women for fertility. For obvious reasons, women are exposed to the most risk during pregnancy, labor and delivery. Thinking back to last week’s discussion of gender, the female gender role dates back thousands of years; women have long been held responsible for the outcomes of pregnancy e.g. Queen in the Middle Ages blamed for birthing a daughter when King needed an heir, a son.

Recognizing the burdens we shoulder as women and especially when seeking fertility treatments helps us articulate how uniquely frustrating and difficult it is for women. In doing so, we realize how very strong we are to be able to carry it all.

A Unique Opportunity
Pregnancy offers a unique 10-month opportunity to develop a great support system, emotional expression and coping skills. In this way, you can take advantage of the sense of calm you may experience while pregnant to create a lasting sense of calm that stays with you throughout the post-partum period and life.

Prompt for group leader: Ask the group ‘What behaviors have increased or decreased during pregnancy for you? Why do you think that is?’

Emotional Expression Skills (EES)
Develop a self-care plan:
Positive Thinking
Be task-oriented. Feel good about your efforts and accomplishments
Accept yourself. Try to avoid self criticism.
Be flexible. Nothing is black and white.
Develop realistic goals
Develop a positive view of life
Nurture your spirituality
Deep breathing, relaxation, meditation, or visualization
Find humor in things
Keep a journal for venting; end every entry with something positive
Practice good communication
Take short breaks during the day to relax, remove yourself from stressors
Do things that demonstrate respect, care, and nurturing of yourself
*see the Google Site for more information on EES and more EES to come in Session 3

Discussion: Does thinking your role in pregnancy trigger any anxious thoughts? What are they?

Centering Pregnancy Model
Nurse Sharon Schindler Rising created a ground-breaking program termed “Centering Pregnancy” to coordinate comprehensive prenatal and well-woman health care to expecting mothers (see link below). Mothers of similar gestational age (similar delivery dates) and their partners were invited to join a group that met throughout pregnancy and into the post-partum period. The program involves assessment, education and facilitates a supportive and comforting environment where women are able to allay fears, share concerns and become better equipped to accept the happy challenges of both pregnancy and motherhood.

Pregnancy as a Gift
Though counterintuitive, it may be helpful to step into the shoes of a woman struggling with infertility. Dr. Alice Domar, of the Boston IVF Center, administers an excellent mind-body-health center for women seeking pregnancy. It is comforting and well-written, even for women who have already conceived! (see link below). Reading about the reverence and adoration infertile couples have for pregnancy may allow you to think of the ways in which your pregnancy is a gift.

Exercise At-home: Create a list of the emotional milestones you foresee in post-partum life (e.g. being patient with post-partum weight loss, returning to work, etc)

References:
The Trauma Focused Cognitive Behavorial Therapy Manual, from the The North Carolina Child Treatment Program, Advanced Training Institute
Johnson, Sharon L. Therapist's Guide to Clinical Intervention: The 1-2-3's of Treatment Planning
Mind-body-health.blogspot: http://www.domarcenter.com/blog/category/health/mindbody/
Appendix III. Flyer for “Fertility and Female Empowerment” Course:

Fertility and Female Empowerment Support Group

Questions or concerns about your fertility?
Trying to get pregnant?

You’re not the only one!!!

Share a supportive learning experience with women like you in an upcoming support group at MEDA.

Please Email info@medainc.org with interest in joining us for an upcoming private support group for women on issues of fertility (subfertility, infertility or general knowledge)
Appendix IV. Program Evaluation: Pre and Post-Course Survey

Pre-Course Survey

This survey is 100% anonymous. DO NOT write your name or anyone else’s name on this survey. Please answer each question honestly, skipping any that make you feel uncomfortable. Thank you for sharing!!

Section I. Knowledge
1. I know how to build a support network.
   Always    Most of the time    Some of the time    Never
2. I know how to recognize when I need support.
   Always    Most of the time    Some of the time    Never
3. I know how to articulate myself when I need support.
   Always    Most of the time    Some of the time    Never
4. I have a good understanding of emotional expression skills.
   Always    Most of the time    Some of the time    Never
5. I know what emotional coping mechanisms are and which work best for me.
   Always    Most of the time    Some of the time    Never
6. I know what media literacy is.
   Always    Most of the time    Some of the time    Never

Section II. Attitudes & Beliefs
7. I have an adequate support system
   Always    Most of the time    Some of the time    Never
8. I feel well-prepared to ask for more support when I encounter unforeseen difficulties (e.g. after I begin fertility treatments, after my baby arrives, etc.).
   Always    Most of the time    Some of the time    Never
9. I have worries about my role as a current/future mother.
   Always    Most of the time    Some of the time    Never
10. I worry I won’t have enough support once my baby arrives (or once I begin fertility treatments).
    Always    Most of the time    Some of the time    Never
11. I believe women feel pressure from the media to achieve a certain body size (e.g. lose weight quickly after pregnancy).
    Always    Most of the time    Some of the time    Never
12. I feel empowered to assert myself in stressful situations.

   Always  Most of the time  Some of the time  Never

13. I am equipped to assert myself.

   Always  Most of the time  Some of the time  Never

Section III. Behaviors

14. Does your partner know about your eating disorder history? (Circle Yes or No)

15. Do your Primary Care Physician, Obstetrician, gynecologists and/or fertility doctor know about your eating disorder history? (Circle Yes or No)

16. How often do you share life stressors with your partner?

   Always  Most of the time  Some of the time  Never

17. I’ve identified which stressors are likely to trigger urges for me.

   Always  Most of the time  Some of the time  Never

18. I recognize when I’m having an urge to restrict or purge.

   Always  Most of the time  Some of the time  Never

19. I’ve identified emotional coping mechanisms that work well for me.

   Always  Most of the time  Some of the time  Never

20. What topic do you hope to learn more about?

   ____________________________________________________________

21. Are you planning to/excited to use the course Google Site? Why or Why not?

   ____________________________________________________________
Post-Course Survey
This survey is 100% anonymous. DO NOT write your name or anyone else’s name on this survey. Please answer each question honestly, skipping any that make you feel uncomfortable. Thank you for sharing!!

Section I. Knowledge
1. I know how to build a support network.
   Always Most of the time Some of the time Never
2. I know how to recognize when I need support.
   Always Most of the time Some of the time Never
3. I know how to articulate myself when I need support.
   Always Most of the time Some of the time Never
4. I have a good understanding of emotional expression skills.
   Always Most of the time Some of the time Never
5. I know what emotional coping mechanisms are and which work best for me.
   Always Most of the time Some of the time Never
6. I know what media literacy is.
   Always Most of the time Some of the time Never

Section II. Attitudes & Beliefs
7. I have an adequate support system
   Always Most of the time Some of the time Never
8. I feel well-prepared to ask for more support when I encounter unforeseen difficulties (e.g. after I begin fertility treatments, after my baby arrives, etc.).
   Always Most of the time Some of the time Never
9. I have worries about my role as a current/future mother.
   Always Most of the time Some of the time Never
10. I worry I won’t have enough support once my baby arrives (or once I begin fertility treatments).
    Always Most of the time Some of the time Never
11. I believe women feel pressure from the media to achieve a certain body size (e.g. lose weight quickly after pregnancy).
    Always Most of the time Some of the time Never
12. I feel empowered to assert myself in stressful situations.
    Always Most of the time Some of the time Never
13. I am equipped to assert myself.
   Always  Most of the time  Some of the time  Never

_section III. Behaviors_

14. Does your partner know about your eating disorder history? (Circle Yes or No)

15. Do your Primary Care Physician, Obstetrician, gynecologists and/or fertility doctor know about your eating disorder history? (Circle Yes or No)

16. How often do you share life stressors with your partner?
   Always  Most of the time  Some of the time  Never

17. I've identified which stressors are likely to trigger urges for me.
   Always  Most of the time  Some of the time  Never

18. I recognize when I'm having an urge to restrict or purge.
   Always  Most of the time  Some of the time  Never

19. I've identified emotional coping mechanisms that work well for me.
   Always  Most of the time  Some of the time  Never

The following questions will help us improve the course. Thank you for sharing!

20. This course helped me feel more equipped for my role as a woman, wife and/or mother.
   Always  Most of the time  Some of the time  Never

21. I feel this group was too educational.
   Always  Most of the time  Some of the time  Never

22. I feel this course was too discussion-based.
   Always  Most of the time  Some of the time  Never

23. I feel this course over-emphasized skill-building.
   Always  Most of the time  Some of the time  Never

24. I enjoyed the Google Site that accompanied the course.
   Always  Most of the time  Some of the time  Never

25. I wish the course was longer/shorter than 8 sessions (circle longer or shorter)

26. I wish each session was longer/shorter than 1 hour (circle longer or shorter)

27. What was your favorite session/topic? ________________________________
28. What was your least favorite session/topic? ___________________________

If anything, what did we spend too much time on?

_____________________________________________________________________

If anything, what did we spend too little time on?

_____________________________________________________________________

Overall, what aspects did you like or dislike about the Course?

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

What did you like or dislike about the Google Site?

_____________________________________________________________________

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