Eating Disorders in Pregnancy and Breastfeeding: Why ‘Eating Healthy’ Isn’t Always Easy

At some point, most of us have been told to “eat healthy.” Sounds simple enough, right? But what that means can look different from person to person. For some, it’s about cutting back on junk food and adding more fruits, vegetables, and whole grains. For others, it might mean watching sodium intake, choosing foods that support heart health, or managing cholesterol levels.

No matter your health history, eating well is something we’re all encouraged to do, especially during pregnancy and while breastfeeding, when your body is supporting both you and your baby.

But if you’re living with an eating disorder, pregnancy or breastfeeding can add extra layers of complexity. It’s not just about ***what*** to eat anymore: questions about ***how much*** to eat, ***how often*** to eat, and how to manage hunger cues or body changes can feel overwhelming. These challenges are real, and they deserve thoughtful, compassionate support.

A few years ago, I received a call from a woman named “Alice.” She called MotherToBaby because she was taking medication for high blood pressure and wanted to know if it would affect her pregnancy. After some discussion, she told me her blood pressure was high because she was quickly gaining a lot of weight from binge eating. She said she had been binge eating for a long time and did not know how to stop. She was worried about how this would affect not only her health, but also that of her baby. When I asked what her healthcare provider suggested, she told me she was afraid to talk to her midwife about it.

What is an eating disorder?

An eating disorder is a mental health disorder that results in serious disturbances of eating behavior. There are several different eating disorders, including anorexia nervosa, bulimia nervosa, binge eating disorder, and pica. Each disorder has its own symptoms and effects. In the United States, 9% (28 million) of people will have an eating disorder in their lifetime.

- Anorexia nervosa –severely restricting the amount of food eaten, resulting in very low body weight.
- Bulimia nervosa – binge eating (eating large amounts of food in a short time and feeling loss of control overeating) and then purging (vomiting, not eating, over-exercising, misusing laxatives or diuretics).
- Binge-eating disorder- binge eating without purging.
- Pica – a craving for and eating of substances without any nutritional value (such as ice, clay, paper, or dirt) for at least one month. The number of women affected by pica is unknown, but it is much more common in pregnant women than in non-pregnant women; it is also more common in developing countries than in the US.

Eating disorders can be hard to spot under any circumstances, and that can be even more true during pregnancy and after a baby is born. So much focus is placed on weight changes, appetite shifts, and body changes during this time that warning signs can easily be overlooked or explained away as “just part of pregnancy.” Also, not all healthcare providers receive specialized training in recognizing eating disorders, especially in pregnant or postpartum patients. That means symptoms can sometimes go unnoticed, even during regular prenatal or postpartum visits.

There’s also a lot of stigma surrounding eating disorders. Some women may feel embarrassed, ashamed, or afraid to speak up about their struggles. Others might worry about being judged or not being taken seriously. All of that can make it incredibly difficult to admit that something isn’t okay.

Can eating disorders affect my pregnancy?

A healthy, well-balanced diet during pregnancy is important for a fetus to grow and develop. It can also help to minimize some pregnancy symptoms such as nausea and constipation. Certain eating-disorder behaviors can cause issues during pregnancy and may require hospitalization or other specialized care. For example:

- Not eating and/or calorie restriction can cause low energy and nutritional gaps in the mother and low birth weight for the baby.
- Vomiting can cause dehydration, electrolyte imbalances, sore throat, stomach pain, tooth damage, gum disease, and ruptured esophagus in the mother.
- Using laxatives/diuretics can cause dehydration, electrolyte imbalances, laxative dependency, and organ damage in the mother.
- Over-exercising can lead to fatigue, muscle pain/soreness, dehydration, and overheating in the mother.
- Binge eating can lead to excessive weight gain, gestational diabetes, high blood pressure (and other complications) in the mother, and large birth weight for the baby.
- Eating non-food substances (pica) can interfere with nutrient absorption and may contain dangerous substances that could be harmful to mom or baby. See our fact sheets on toxoplasmosis and lead.
- Mental health issues, such as depression or anxiety, go hand in hand with eating disorders. Learn more about how mental health disorders can affect pregnancy and breastfeeding.

What about breastfeeding?

Getting sufficient “high quality” calories is important for everyone. During breastfeeding, the body needs energy to make enough milk, and not getting enough calories can make it harder to do. For pica, non-food items may contain something potentially harmful to the baby, such as lead.

Studies have suggested that women with eating disorders might be more likely to stop breastfeeding within the first 6 months. However, it is possible to successfully breastfeed with an eating disorder, even if they are taking medications. The key is finding support, which you can get from healthcare providers (doctors, nurses, lactation consultants), family, friends, and support groups (online, over-the-phone, and in person).

Help is Available

If you have been diagnosed with an eating disorder, or think you may have one, talk with your healthcare provider. You are not alone. There are resources available to help you and your baby be as healthy as you can be.

Talk to your healthcare provider to discuss how many calories per day are right for you. There are many resources available to help educate people about good food choices, such as the Americal College of Obstetrics and Gynecology’s Frequently Asked Questions on healthy eating during pregnancy. The National Institutes of Health has information on which foods/drinks to limit/avoid, the appropriate amount of weight to gain, and the recommended amount of exercise.

And finally…

So, what happened to Alice? She called several times throughout her pregnancy and while breastfeeding. After our first conversation, she told her midwife everything. Alice did develop gestational diabetes, but under the care of her midwife, nutritionist and counselor, she was able to stop gaining weight and get her blood sugar and blood pressure under control. She gave birth to a healthy baby and continued to work with her team during breastfeeding. She thanked me for suggesting she ask for help and said she was closer to finding something we all are looking for – balance.

Originally authored by Chris Stallman Aug. 2, 2018, edited by Bridget Maloney, Certified Genetic Counselor at MotherToBaby Arizona, on February 17, 2026.

Eating Disorders in Pregnancy and Breastfeeding: Why ‘Eating Healthy’ Isn’t Always Easy

Can you guess the leading cause of infant hospitalizations in the United States? You might think accidents, allergic reactions, or the flu, but the answer is actually respiratory syncytial virus (RSV). Every year, RSV sends 58,000 to 80,000 children under the age of 5 to the hospital.

Having a baby in the fall or winter has always meant that parents need to be extra careful about RSV. Fortunately, in 2023 two new ways to protect infants against this virus became available: a vaccine given to women between 32 and 36 weeks of pregnancy and an antibody (passive immunization) that is given directly to babies after birth. Today, we’re covering some of the most common questions we get at MotherToBaby about RSV prevention.

Q: What is the maternal RSV vaccine? When is it given?

The maternal RSV vaccine (brand name Abrysvo®) is a protein subunit vaccine (it contains proteins the body needs to make antibodies against RSV). The vaccine does not contain live virus that can cause RSV. When a woman gets the RSV vaccine during pregnancy, the antibodies she makes can also pass to the developing fetus. These antibodies can

help protect the baby from RSV during the first 6 months of life.

The Abrysvo® RSV vaccine can be given to women who are 32 to 36 weeks pregnant who have not received a maternal RSV vaccine in a previous pregnancy. The RSV vaccine is only recommended for use during pregnancy between September and January in most of the United States.

Q. What is an infant RSV antibody? When is it given?

Infant antibodies, also called passive immunizations, are another effective way to help protect babies from RSV. Two RSV antibodies are currently available: nirsevimab (Beyfortus®) and clesrovimab (Enflonsia®). The RSV antibody is recommended for infants younger than 8 months who are entering their first RSV season if their mothers did not receive the maternal RSV vaccine during pregnancy. Infants and children ages 8 to 19 months who are at high risk for severe RSV illness and entering their second RSV season may also be eligible for the antibody. The RSV antibody is available between October and March for most of the United States and starts working immediately after it is given.

For more information about timing, eligibility, and benefits of infant RSV antibodies, talk with your child's pediatrician.

Q: Is one of these options better than the other?

Patients can choose either the maternal vaccine or the infant antibody. Both are great options for protecting infants against RSV, and there is currently no preference for one over the other. A slight benefit of getting the RSV vaccine during pregnancy is that most babies will be born with immediate protection if the vaccine is given at least 2 weeks before delivery. Some parents might also prefer the maternal vaccine because it avoids an extra injection (shot) for the baby.

Q. How do we know the RSV vaccine is ok to get in pregnancy?

Studies on the Abrysvo® RSV vaccine have not found a higher chance of birth defects. It's also reassuring to note that the vaccine is given in the third trimester (between 32 and 36 weeks), which is past the critical period when most birth defects could happen.

Early clinical trials on the vaccine observed slightly more preterm births in women who received the Abrysvo® RSV vaccine than in those who did not (5.7% in the vaccinated group vs. 4.7% in the placebo group). However, newer data from larger studies has not found a higher chance of preterm birth following RSV vaccination in pregnancy. Check out the MotherToBaby RSV vaccine fact sheet for more information on this topic.

Q. If I got an RSV vaccine in my last pregnancy, do I need to get it

again in my next pregnancy?

The simple answer is no. At this time, the maternal RSV vaccine is only recommended for women who have not gotten it in a previous pregnancy. Researchers need time to determine if getting the vaccine once can provide ongoing protection for future pregnancies, or if a booster dose is needed in every pregnancy.

If you received the RSV vaccine during a previous pregnancy and are pregnant again, your baby can get an infant RSV antibody to help ensure they are protected.

Making Your Choice

No matter whether you decide on the maternal RSV vaccine or an infant RSV antibody, you're making a great choice to protect your baby from RSV! Still have questions? Remember that MotherToBaby can be reached by chat, text, phone, or email with questions about the RSV vaccine or any other exposure in pregnancy or while breastfeeding.

Eating Disorders in Pregnancy and

Breastfeeding: Why ‘Eating Healthy’ Isn’t Always Easy

Thinking about pregnancy while also worrying about weight can feel stressful. You are not alone—about 6 in 10 women in the U.S. are overweight or have obesity. Talking about weight can be hard, but it is an important part of planning for a healthy pregnancy.

This blog will explain how weight can affect pregnancy, what GLP-1 medications are, and what we know so far about their use before and during pregnancy.

Why Is Managing Weight Before Pregnancy So Important?

Being overweight or having obesity increases the chance for several pregnancy-related problems, including:

- Miscarriage
- Birth defects
- Preterm delivery (before 37 weeks)
- Gestational diabetes
- High blood pressure during pregnancy
- Stillbirth
- Cesarean delivery
- Thromboembolic events (blood clots)

You can read more about obesity and pregnancy in our factsheet here:
https://mothertobaby.org/fact-sheets/obesity-pregnancy/

The good news is even a small weight loss—just 5–7% of your body weight—before pregnancy can improve health and pregnancy outcomes. Starting before you get pregnant is best. Some people do this through healthy eating and exercise, while others may need surgery or medication.

What Are GLP-1 Medications?

GLP-1s are medicines that act like a natural hormone in your body. They help control blood sugar, slow down digestion, and make you feel full longer. This can lead to weight loss. Most GLP-1s are given as shots. The best-known ones are liraglutide (Victoza®) and semaglutide (Ozempic®, Wegovy®, Rybelsus®). These are also the ones most studied in pregnancy so far.

Can I Use GLP-1s While Trying to Get Pregnant?

The current product labels recommend stopping GLP-1 medications at least 2 months before pregnancy. The time it takes the body to process medication is not the same for everyone. In healthy non-pregnant women, it can take up to 6 weeks, on average, for most of the GLP-1s to be gone from the body.

Stopping the medicine can sometimes cause weight gain, which can feel frustrating. Because of this, some people choose to continue until they know they are pregnant. It's best to talk with your healthcare provider about the risks and benefits for you.

What Do We Know About GLP-1s in Pregnancy?

Here's what research tells us so far:

- Studies including over 1,000 women exposed to GLP-1s during the first trimester have not shown an increased chance of birth defects.
- A study of 168 pregnancies with first-trimester exposure to GLP-1s did not show increased chance of miscarriage, preterm delivery, stillbirth, or SGA infants (small for gestational age-infants whose birth weight is below the 10^{th} percentile for their gestation age).

It's important to remember that every pregnancy has a baseline risk:

- Out of all babies born each year, about 3 out of 100 (3%) will have a birth defect
- 15 to 20 out of every 100 (15-20%) pregnancies end in miscarriage

These typically occur in the first trimester — whether or not medication is used.

Why Are GLP-1s Not Recommended During Pregnancy?

At this time, continuing GLP-1s after pregnancy is confirmed is not recommended for two main reasons:

- Weight loss during pregnancy is not advised. Losing weight while pregnant may increase the chances of having a baby with SGA, which can lead to complications such as:
    - Low oxygen levels
    - Low Apgar scores (grading system in newborns to define their wellbeing)
    - Meconium aspiration (breathing in the first bowel movement)
    - Hypoglycemia (low blood sugar)
    - Difficulty maintaining body temperature
    - Polycythemia (too many red blood cells)

- We lack research on GLP-1s in the second and third trimesters. Without research studies on the use in the second and third trimester, we don't know if use of GLP-1s could increase the chances of other pregnancy-related problems.

Finding the Path That's Right for You

Your journey is unique, and there's no simple answer. That's why it's so important to talk with your healthcare provider about the best way to approach weight management before pregnancy. As Dr. Sarah Obican so masterfully said in a previous Baby Blog post:

"Each of us are beautifully individual" — and our weight loss and pregnancy journeys are beautifully individual, too.

Final Thoughts

Whether you're already on a weight loss journey or just starting to think about pregnancy, you deserve support and trusted information. We're here to help you every step of the way.

Helpful Links:

Factsheets:

- Obesity and Pregnancy:https://mothertobaby.org/fact-sheets/obesity-pregnancy/
- Semaglutide: https://mothertobaby.org/fact-sheets/semaglutide/

Baby Blogs:

- Battling Obesity Ahead of Pregnancy is 'Beautifully Individual':https://mothertobaby.org/baby-blog/battling-obesity-ahead-of-pregnancy-is-beautifully-individual/

Podcasts:

- Ep. 84: GLP-1 Medications & Pregnancy: What We Know So Far: https://mothertobaby.org/podcast/ep-84-glp-1-medications-pregnancy-what-we-know-so-far/
- Ep. 64: Weight Loss and Ozempic in Pregnancy: https://mothertobaby.org/podcast/ep-64-weight-loss-and-ozempic-in-pregnancy/

Have questions about a specific medication or concern? Reach out to our MotherToBaby experts by phone, text, email or live chat at MotherToBaby.org.

Eating Disorders in Pregnancy and Breastfeeding: Why ‘Eating Healthy’ Isn’t Always Easy

By Lorrie Harris-Sagaribay, MPH, President of OTIS/MotherToBaby, in partnership with Joanne Samuel Goldblum, CEO and founder of National Diaper Bank Network.

MotherToBaby is proud to partner with the National Diaper Bank Network (NDBN) as the organization marks its 15th anniversary in 2026 – celebrating a decade and a half of supporting families across the country by ensuring access to diapers and other essential material needs. Through our partnership, we’ve learned that many parents and caregivers, especially those who are pregnant or caring for newborns, often ask the same kinds of questions about everyday exposures during pregnancy and lactation.

These concerns come straight from the field, as NDBN staff and volunteers working directly with families hear questions like these every day. To help answer them, MotherToBaby experts weigh in on some of the families’ most common questions about pregnancy and breastfeeding exposures.

First, it’s important to remember that birth defects can happen in any pregnancy for different reasons. Out of all babies born each year, about 3 out of 100 (3%) will have a birth defect. Pregnancy problems (like miscarriage) can also happen in any pregnancy. MotherToBaby looks at research studies to understand if a certain exposure could increase the chance of birth defects or other problems in a pregnancy.

Here are five of the exposures that NBDN families ask about most frequently:

1. Caffeine

During pregnancy, it's recommended to keep your caffeine intake to less than 200 milligrams (mg) per day from all sources, including coffee, tea, energy drinks, and chocolate. (For reference, an 8-ounce cup of brewed coffee can contain 70 to 140 mg of caffeine, depending on the type of coffee and how it is brewed.) During breastfeeding, it's been suggested to stay under 300 mg per day, although that amount might be too high when the baby is very young (it takes young babies much longer than adults to process, or metabolize, caffeine). Even some older babies can be more sensitive to caffeine than others are. If you notice that your baby seems jittery, irritable, or wide awake in the middle of the night after you drink caffeine, you could consider cutting back.

Let's talk more about ***energy drinks***. Most energy drinks contain not only caffeine, sugar, and B vitamins, but also herbal ingredients that most likely haven't been studied in pregnancy or breastfeeding. This means there is no information about how much of these ingredients might reach the developing baby during pregnancy or get into the breast milk. For this reason, it might be preferred to hold off on energy drinks until you aren't pregnant or breastfeeding any longer.

2. Over-the-Counter Pain Medications

Two of the most common over-the-counter pain medications are acetaminophen (such as Tylenol®) and ibuprofen (such as Advil®). These pain relievers are also found in multi-symptom products, such as cold medications. During pregnancy, using acetaminophen for a short time when directed by a healthcare provider to treat pain or fever has not been shown to increase pregnancy risks. Acetaminophen should be used as directed and only for as long as you need it to treat your condition. Ibuprofen, on the other hand, is typically not recommended in pregnancy, especially in the second half of pregnancy, unless your healthcare provider has specifically advised using it.

During breastfeeding though, acetaminophen and ibuprofen can both be used as directed without expected side effects for the baby. The amount of acetaminophen or ibuprofen that gets into the breast milk is much less than the dose that could be given directly to an infant.

3. Fish and Mercury

You might have heard a rumor that eating fish is not a good idea during pregnancy. But this is not the case. While it's true that most fish could contain some amount of mercury (or more specifically, a form of mercury called methylmercury), these amounts are often too small to increase pregnancy risks as long as you make thoughtful choices about eating fish.

The amount of methylmercury in fish gets higher as fish move up the food chain. Big predatory fish that eat smaller fish usually have higher levels of methylmercury. These big fish include swordfish, marlin, bigeye tuna, and king mackerel, among others. These fish should be avoided during pregnancy and while breastfeeding.

Other kinds of fish can be enjoyed in moderation (1 to 3 servings per week, depending on the kind of fish and where it is caught). The U.S. Food & Drug Administration (FDA) and United States Environmental Protection Agency (EPA) developed a helpful guide that lists many kinds of fish and gives advice on how often they can be eaten by women

who are pregnant or breastfeeding and by children ages 1-11 years: https://www.fda.gov/food/consumers/advice-about-eating-fish.

4. Cleaning Products

Is it better to use natural cleaning products like vinegar during pregnancy or while breastfeeding? What about when you have a young child in the home?

The way you use a cleaning product is usually more important than what the product is. Although using vinegar as a cleaner isn't expected to increase risks during pregnancy or while breastfeeding, there could be some surfaces or situations that require more effective products for sanitizing and disinfecting. In order for a chemical to be able to reach a developing baby during pregnancy or to get into the breast milk, the chemical first has to be circulating in your bloodstream. As long as a product is used in a well-ventilated area (open doors or windows, turn on fans) and your skin is protected from direct contact with the cleaner, then using the cleaner as directed is unlikely to result in an exposure that would get into your bloodstream. If you start to feel any symptoms, such as nausea, dizziness, or headache, increase ventilation in the area and get some fresh air. If you do use vinegar to clean, be sure not to mix it with ammonia or other chemicals, as that can create harmful fumes. With any cleaning product, follow the directions on the label for how to use and store it.

As far as what kinds of cleaners are preferred when you have young children in the home, that is a great question to talk about with your child's healthcare provider.

5. Animal Dander/Feces

Common household pets like dogs, cats, and rodents tend to be furry. Although pet dander itself is not known to be harmful during pregnancy or while breastfeeding, dander could increase the chance of breathing problems if you have significant allergies or asthma. If you are experiencing worsening symptoms of allergies or asthma during your pregnancy, be sure to talk about it with your healthcare provider. It's also a good idea to wash your hands after handling any kind of rodent, even sweet, furry, household pets.

What about animal feces? It's best to avoid direct contact with any animal feces during pregnancy. This means you get a free pass on cleaning the gerbil cage or scooping the litterbox, if possible. Cat feces, in particular, can contain a parasite responsible for an infection called toxoplasmosis, especially if the cat is allowed outside or is fed raw meat. A toxoplasmosis infection during pregnancy increases the chance of pregnancy complications, and could even pass to the fetus. There's no need to rehome your cat or avoid petting it, but you should avoid direct contact with the cat's feces while you are pregnant.

Closing Thoughts

Through our partnership with NDBN, MotherToBaby is committed to answering the real questions families are asking—accurately, clearly, and compassionately. We know that parents want the best for their babies, and they deserve trusted, evidence-based information to make informed choices.

If you or someone you know has questions about exposures while pregnant or breastfeeding, you can contact a MotherToBaby specialist for free and confidential information via phone, text, or chat at MotherToBaby.org.

Together with NDBN, we'll continue listening, learning, and supporting families when it matters most.

More About the National Diaper Bank Network

The National Diaper Bank Network (NDBN) leads a nationwide movement dedicated to helping individuals, children and families access the basic necessities they require to thrive and reach their full potential…including clean, dry diapers, period supplies and other basic needs. Launched in 2011 with the support of founding sponsor Huggies®, NDBN is dedicated to creating awareness of diaper need/diaper insecurity and advocating for public policy to end it. The Network is made up of more than 300 basic needs banks serving local communities throughout the U.S. More information on NDBN and diaper need is available at nationaldiaperbanknetwork.org, and on Twitter (@DiaperNetwork), Instagram (@DiaperNetwork) and Facebook (facebook.com/NationalDiaperBankNetwork).

Eating Disorders in Pregnancy and Breastfeeding: Why 'Eating Healthy' Isn't

Always Easy

By Beth Kiernan, MPH, Interviewer & Teratogen Information Specialist, MotherToBaby

Kristin called MotherToBaby one afternoon saying, “I just took a home pregnancy test and it’s positive.” Kristin sounded beyond worried. “I’ve been taking a medication for ADHD since I was eight years old, and when I searched the internet it said it was harmful and that I should stop taking it before getting pregnant.” Kristin hadn’t planned on getting pregnant. Now, not only was she terrified she had hurt her unborn child, but she also found it impossible to think about stopping the medication for a very good reason: “I am a nurse in the Cardiac Intensive Care Unit at a hospital – staying focused is critical to the lives of my patients.”

Kristin isn’t alone in her concerns.
This is one of the most frequent topics asked about by people who contact MotherToBaby, which isn’t really surprising. About 1.4 million people in the U.S. have been diagnosed with Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD). Since nearly half of pregnancies in the U.S. are unplanned, her situation isn’t uncommon.

ADD and ADHD are chronic conditions often diagnosed in childhood. They cannot be cured, but can be treated with behavioral counseling/coaching, medication, or both. If you or someone you know are affected by ADD/ADHD, you know that there are some classic things that can be challenging, including difficulty staying organized at home and at school or work, problems with sleep, being distracted, acting without thinking things through, having trouble behaving appropriately, struggling to finish tasks, having a short temper, talking too much, feeling anxious or restless or bored, and sometimes addictive tendencies.

About 60%-80% of kids diagnosed with ADD/ADHD will need to take their medications into adulthood, since it often helps them in daily life. But what about when a woman with ADD/ADHD gets pregnant? This was Kristin’s concern, and Dr. Google (searching the internet for medication advice in pregnancy) isn’t the recommended solution! Thankfully for Kristin, this is our specialty here at MotherToBaby. We talk with women about all their medication choices and concerns, referring to key research to educate them. This gives them the information they need to discuss their medication choices with their healthcare providers.

Kristin was taking Ritalin.
Ritalin is a stimulant medication also called methylphenidate. Kristin’s concern reflects the fact that Ritalin is grouped with other stimulants like amphetamines and methamphetamine, so it can be hard to untangle the research when everything is lumped together in discussions of pregnancy. Obviously, drugs used in an addictive way like “meth” or “speed” aren’t advised in pregnancy because research has shown negative effects, like pregnancy complications and postnatal problems in behavior, emotions, memory, attention, and growth. However, taking a prescribed daily dose of methylphenidate or other ADD/ADHD medications during pregnancy hasn’t shown increased risks for having a baby with a birth defect. Nor have we seen an increased risk for pregnancy complications like preterm delivery or low birth weight. Plus, babies exposed to prescription levels of methylphenidate in utero that were studied up to a year of age have had normal development.

I told Kristin that, for people like her with ADD/ADHD, methylphenidate can really promote success at work, in school, and in getting along with other people. Going off this medication can create problems, so it’s good to know that the data we have on its effects in pregnancy is reassuring.

Other side effects of ADD/ADHD medications on a pregnancy.
I also shared with Kristin some pregnancy-specific information: sometimes people who take methylphenidate feel less hungry, and when combined with pregnancy this may lead to weight loss. Similarly, changes in the body while pregnant can mean that the prescribed daily dose level may need to be periodically changed during pregnancy to adequately treat ADD/ADHD. Lastly, stimulants can affect heart rate and blood pressure. I told Kristin that if she had any of these issues while pregnant, she should call her healthcare provider. And I added that if she still felt nervous about taking her medication, that perhaps her doctors could help her find other ways to manage her ADHD.

Still concerned, Kristin asked if her baby might be born addicted to Ritalin. I explained to her that sometimes babies exposed to stimulants right up until birth have shown symptoms of withdrawal after delivery. When babies have this condition, they may have trouble eating, may sleep too little or too much, may have very floppy or stiff muscles, or be

jittery. These usually disappear within 1-2 weeks and there are no lasting effects. Babies who have more severe symptoms may have to stay in the hospital a little longer to be treated. However, we wouldn't expect this level of withdrawal to occur with regular use of methylphenidate that is taken as prescribed by a doctor. In addition, it's hard to predict if withdrawal symptoms will even happen. It's seen more often when women take opioids and other medications for mental illness and epilepsy. With daily doses of methylphenidate, it's possible that her baby could have mild symptoms or no symptoms, even if Kristin needed to take it until delivery.

What about breastfeeding?
Finally, Kristin said that, while she hadn't planned to be pregnant, she was excited about it, and hoped to breastfeed too since she'd heard that was best for her baby. She asked if she could continue to take her Ritalin and nurse her baby. I told her that small amounts of methylphenidate have been found in studies on breastmilk, but that the levels are so low that it wouldn't be expected to cause problems. Normal sleeping and feeding have been reported in the exposed infants. I suggested she also speak with her pediatrician about it once she found one in her insurance network.

In the end, Kristin told me that she felt very relieved to get a full understanding of her situation, and to be able to more accurately understand the possible risks to her pregnancy versus the benefits for her of staying on her medication. Now she can "focus" on preparing for the next chapter in her life: impending motherhood!

***Beth Kiernan, MPH, is a Teratogen Information Specialist with* MotherToBaby Pregnancy Studies,** *a non-profit that conducts observational research about exposures in pregnancy and provides information to healthcare providers and the general public on medications and more during pregnancy and breastfeeding. She is based at the University of California, San Diego, and is a married mother of four children.*

About MotherToBaby

***MotherToBaby** is a service of the Organization of Teratology Information Specialists (OTIS), suggested resources by many agencies including the Centers for Disease Control and Prevention (CDC). If you have questions about exposures, like medications to treat ADD/ADHD, during pregnancy and breastfeeding, please call MotherToBaby toll-FREE at 866-626-6847 or try out MotherToBaby's new **text information service** by texting questions to (855) 999-3525. You can also visit **MotherToBaby.org** to browse a library of fact sheets about dozens of viruses, medications, vaccines, alcohol, diseases, or other exposures during pregnancy and breastfeeding or connect with all of our resources by downloading the new MotherToBaby free app, available on **Android** and **iOS** markets.*