Eating Disorders in the perinatal period

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Summary:

- Eating disorders in pregnancy
- Overview
- Factors that impact eating disorders
- What keeps the eating disorder going?
- Consequences of starvation, purging and binging
- Vicious cycle of Eating disorders
- Does & Don’ts
- Capacity assessment in EDs
- Support for Maternity caring for Women with Eds – joint care
- Online resources for Professionals and patients
- Reading recommendations
- Case discussion

Overview ED in perinatal period

- Affects 7.5% of women in perinatal period
  - With active or past ED
  - Relapses: antenatal and postnatal
  - Frequently associated with anxiety and depression
- Aetiology is multifactorial; High heritability; 58–88%
- Prevalence and incidence:
  - Prevalence from: 2% to 7,5% overall ED with AN 0.5%, BN 0.1%, BED 1.8%
  - 1/4(23.4%) of women reported high weight and shape concern during pregnancy
  - Remission: higher in the purging subtypes (30-78%)
  - Binge eating increased in the perinatal period - was allowed by 8.8%
  - 2.3% engaged in regular compensatory behaviours
- Mortality:
  - Ratio: 5.86 for Anorexia N, 1.93 for Bulimia N, and 1.92 for OSFED
  - 1 in 5 in Anorexia nervosa complete suicide
  - Bulimia Nervosa - high risk of attempt suicide - ↑ in Purging subtype of EDs (20-30% vs 7.4%) & hx previous trauma

Howard at al, 2018; Bulik at al, 2007; Easter at al, 2013; BEAT, 2019; Kessley et all, 2013; Solmi at al, 2014

Factors that impact eating disorders (EDs)

- Contributing factors:
  - significant life events, exposure to stress e.g. previous infertility, previous losses
  - exposure to increase anxiety and depression – e.g. IVF pregnancy, if obstetric risks/complications, eg. prematurity, small for gestational age, …
  - Change routines, coping mechanisms
  - Change in body shape and weight increase - common in pregnancy
  - Baby is frequently priority in pregnancy
  - Can take at least 6 months or more for the body to return to pre-pregnancy
- Maintaining Factors:
  - Obsessive compulsive traits
  - Rigidity and excess attention to detail
  - High sensitivity to judgment
  - Low self-esteem
  - High striving & perfectionism

Klump et al., 2009; Lucas, 1992, Bulik et al., 2000; Gorwood at al, 2002; Micali at al, 2012; BEAT, 2019; Kessley et all, 2013; McBride et al., 2007; Arcelus J, 2010; Hudson et al., 2007; Solmi at al, 2014, Branley-Bell, D. et al, 2020

Types of Eating Disorders

Eating disorders are psychiatric illness where there are abnormal eating habits, that may involve either insufficient or excessive food intake. Affect both women (majority) and men.

- Anorexia Nervosa (AN)
  - Restrictive type
  - Purging type
- Bulimia Nervosa (BN)
  - Purging type
  - Non-Purging type
- Binge Eating Disorder (BED)
- Avoidant-restrictive food intake disorder (ARFID)
- Purging disorder

➢ Other Specified Feeding or Eating Disorder (OSFED) (DSM 5)

➢ Other feeding or eating disorders (OFED) (ICD-11)

Severity of EDs

Anorexia Nervosa (AN)

- Mild: BMI more than 17-18
- Moderate: BMI 16- 16.99
- Severe: BMI 14-15.99
- V severe: BMI less than 14

Binge Eating Disorder (BED)

- Mild: **1-3** binge eating episodes per week
- Moderate: **4-7** binge eating episodes per week
- Severe: **8-13** binge eating episodes per week
- V severe: **14 or more** binge eating episodes per week

Bulimia Nervosa (BN)

- Mild: average **1-3** episodes of inappropriate compensatory behaviours per week.
- Moderate: ~ **4-7** episodes of inappropriate compensatory behaviours per week.
- Severe: ~ **8-13** episodes of inappropriate compensatory behaviours per week.
- V severe: ~ **14 or more** episodes of inappropriate compensatory behaviours per week.

Complications of ED in the perinatal period

- Preconception and fertility
- Gynaecological & Obstetric
- Delivery and birth outcomes
- Mental health antenatal and post natal risks
- Impact on the child eating
- Family and carers
- Risks specific of EDs

Delivery and birth outcomes

- Higher rate of CST
  - but not of ventouse or forceps
- In severe AN without adequate weight gain - higher risk of:
  - IUGR, SGA (active or past AN)
  - pre-term delivery
  - breech presentation
  - vaginal bleeding
  - low apgar scores
- In BN
  - Increase risk of miscarriage 2x
- IN BED
  - Increase risks of LGA 3x (9.6% vs 2.5%)
  - GDM

Mazzeo et al, 2006, Gain et al, 2005; Stewart et al, 1987, Bulik et al, 1998, 2009; Ekeus et al, 2006; Micali et al, 2007; Kouba et al, 2005; Mitchell et al, 1991, Solmi et al, 2014; Lewis et al, 1998

Mental health risks in perinatal ED

- ↑ **relapse rate of ED**: w ↑concerns weight/body image & significant and rapid weight loss
  - Way to cope with stress & adjustment to motherhood and sleep deprivation
  - Women are alone long period so easy to return ED behaviours

- ↑ **risk of Antenatal depression** (36 to 39%-59%, AN-BN respectively)
- ↑ **risk of PND and anxiety** (40-46%, in 1/3 women with BN)
  - ~ to risks in women with major depression without ED

  - ↑ risk of poorer outcome for child eg. increase risk of depression in off spring later in life & poorer school achievements – particularly in boys

  - Higher if previous Hx of trauma or abuse
    - Independent risk for: perinatal depression, & pregnancy complication like miscarriage, hyperemesis, premature contractions and delivery complications
    - More frequent in ED purging subtypes (62% vs 29%)

Mazzeo et al, 2006, Gain et al, 2005; Carter et al, 2003; Micali et al, 2010; Morgan at al, 2006

Impact of maternal EDs on the child:

Breastfeeding

- Used as a way of losing weight quicker, long term breastfeeding
- ↓ when high body dissatisfaction - early introduction of formula

Physical growth and development

- Growth restriction - mothers with Anorexia Nervosa

Feeding and eating habits and attitudes

- Eating difficulties (by age 5)
- Body shape and weight concerns (by age 10)
- Dietary restrain by age 10
- Overweight children (mothers chronic depression in high S-E)

Mealtimes

- Increase conflict and negative expressed emotions from mothers with EDs
- Reduced positive reinforcement
- Use of food for non nutritional purposes eg. Reward/soother

Field at al, 2010; Stein & Pearson at al, 2014; Faster et al, 1996; Waugh & Bulik, 1999; Micali et al, 2009;

Co-morbidities in ED

- Anxiety
- Depression
- OCD and/or anankastic traits
- Substance misuse
- EUPD/ PD traits
- High risk of PND & Relapse from ED in perinatal period

Risk of death in Eating Disorders

- Deliberate self harm (DSH)
- Suicide
- Starvation
- Compromised immune system eg. Infections
- Electrolyte imbalances - cerebral oedema or cardiac arrhythmia
- Re-feeding syndrome
- Metabolic syndrome

Symptoms of ED in perinatal period:

- Symptoms similar to other times …
  - Typical of each different type of eating disorder

  But:
  - Some women seems to experience more freq & severe hyperemesis/?SIV
  - Women have more body shape and weight concerns from 1st Trimester, despite not many body changes yet
  - Women struggle more with comments from others, how 'the baby is big' – meaning 'they are fat', …
  - Post Natal- higher struggle with body not being immediately back to pre-pregnancy weight and shape, increased distress as breastfeeding increases appetite, struggle with body exposure in BF

- Some women – ED remains active throughout

- Some women – keep in remission or minimum symptoms in pregnancy as baby is priority – more in BN cases. BED increases. More relapses in pregnancy in non active AN/BN cases.

What Women say:

Pregnancy

- 1St Trimester:

'I am too fat, I cant look at myself

I cannot stop vomiting. Medications don't work

'I don't feel connected to my baby'

I Feel too sick to eat

'I feel huge' 'Nothing fits me anymore'

'I cannot touch my body, even in shower

' I feel out of control'

'I cannot stand my husband touching the bump'

- 2nd/3rd Trimesters:

'People keep commenting of my big baby and makes me feel like a whale'

'Baby is a good reason for my weight'

'I need this baby out as cannot cope more with how I look'

- Some women – ED remains active throughout

Post natal

'I look disgustingly fat'

'I worry about my baby's weight and eating'

' I look awful'

'The only thing I think is my weight and my body'

'my mind keeps telling me to restrict'

When to be very worried

- **Psych Sx**: very rigid/controlling thinking, abnormal beliefs about their weight/body shape, severe anxiety, low mood, low energy levels, suicidal, …

- **Physical Sx**: Shortness of breath, oedema (generalised), cramps, confusion, stabbing epigastric pains,…abdominal distension, chronic constipation, BMI below 17 in pregnancy/loss weight)

- **Bloods**: Low-high K/Na, anaemia, low/normal WCC, neutropenia, raised CK, LFTs, raised T cholesterol, increased amylase, ECG changes/arrythmias

(Note: BP and pulse might be normal don't exclude pre-eclampsia, WCC normal means low WCC/N, cholesterol very significantly raised may not be just pregnancy normal)

Maternity challenges

- It is frequently assumed that women with EDs don't get pregnant
- Women with EDs frequently don't disclose their mental illness(es)

Presentations in maternity - ?ED

- Denial previous ED hx, guarded, dismissive/only speaking food, appetite
- Looking slimmer, baggy clothes
- Some (early) pregnancy symptoms may be confused with EDs symptoms eg. Nausea, hyperemesis, reduced food intake
- Decline to discuss weight/food & drinking intakes/compensatory mec
- Poor weight progression – lack regular weighing
- Poor foetal growth - +++end 2T and 3T
- Pre-term labour, pre-eclampsia, GDM, early IoL, poor suture repair
- Lack cooperation, poor/non attendance

What keeps the eating disorder going… (1)

PROS:

Anorexia Nervosa:

- Safety
- Control
- Avoidance/numbing of emotions
- Different/specialness
- Skill/achievement
- Communication
- Care
- Attractiveness

CONS:

Anorexia Nervosa:

- Preoccupation w food, weight & shape
- Social impact/Isolation
- Take over 24/7
- Pretend to be a friend
- Poor physical health
- Emotions/mood
- Waste
- Cognitive impairment
- Worry to others

What keeps the eating disorder going… (2)

PROS:

BN:

- 'Have your cake and eat it'
- Avoidance / numbing of emotions
- Boredom
- Self-soothing

BED:

- Coping with emotions and stress
- Comfort
- Avoiding or numbing emotions

CONS:

BN:

- Preoccupation with weight & shape
- Negative self-image
- Shame, secrecy, loss of control
- Low self-esteem
- Poor physical health
- Financial
- Worry to others

BED:

- Shame and secrecy
- Guilt
- Loss of control – compulsion
- Isolation
- Overweight and obesity
- Poor physical health
- Joint pains, poor mobility

Eating Disorders screening

- **1st:** Hyperemesis gravidarum - Assess if presence & severity -treat
- **2nd:** Exclude or confirm Eating disorder – **SCOFF screening questions:**

5 questions of **yes** or **no** answers:

- Do you make yourself **S**ick?
- Do you worry that you have lost **C**ontrol over how much you eat?
- Have you recently lost more than **O**ne stone (6Kg) in a 3-month period?
- Do you believe yourself to be **F**at when others say you are too thin?
- Would you say that **F**ood dominates your life?

- **If answer YES (1 or more)**

- **Referral to Local Eating disorder**
- **Referral to specialist Dietitian**
- **Recommend named obstetrician, caseload and MH mw, Enhanced HV**

Recommended investigations in perinatal EDs

Investigations:

- FBC and platelets
- U&E, Creatinine, LFT, GGT, Albumin, CK, Bilirubin, lipid profile, bone profile, Amylase
- TFT, T4, ESR, CRP, Glucose, HbA1c, Vit B12, Magnesium, Phosphate, Vit D, folate, Iron, ferritin levels
- Celiac disease screening (if not yet completed)
- Dexa Scan (every 2yo in Anorexia Nervosa)

Examination:

- BP (sitting & standing), Pulse, Temperature, RR
- ECG (baseline below BMI 16 or purging +++, as needed)

Maternity/GP/Health visitor specific:

- Regular growth scans: inc in the 3T
- Monitoring: Growth & development of baby (regular measures weight and length of baby post delivery, plus monitoring of food intake) – H/V or GP

Eating Disorders in perinatal period

https://youtu.be/Pza62vBFDqk

Recommendations for Women with EDs

- Women with active EDs wishing to conceive, should be:
  - advised to postpone pregnancy – refer for treatment in Specialist ED unit/team - until largely recovered
  - Screen/discuss for abuse of: laxatives, appetite suppressants, diuretics, amphetamines, … which may not be safe in pregnancy.
- Perinatal women with ED:
  - Psychoeducation: preconception or in early pregnancy:
    - body changes in perinatal period, cravings, and hyperemesis gravidarum
    - expected weight gain & nutrition during pregnancy and impact on fetal growth
    - Refer to Eds specialist dietician
  - **Active ED** - Joint care, with midwifes/obstetricians and ED/perinatal psychiatric services/GP/specialist EDs dietician – Caseload, MH M/w and named Obstetrician
  - **Past ED** – Monitoring for signs relapse of EDs and co-morbidities - by maternity, GP, perinatal service – if past HX or suspicious Sx
  - **Recommend extra support in breastfeeding/feeding (from day 1 PN)**: enhanced m/w care + health visitor to monitor infant growth and development/weaning
  - **Involve family:** the partner as much as possible, throughout the pregnancy and postpartum period - improves outcomes

Medication in EDs

- Almost exclusively to manage co-morbidities and physical Sx
- Should be managed ideally by an Eating disorder service
- Perinatal service should advice on medications in perinatal period

- Low weight pts = higher doses of psychotropic medications - +++ BMI <16 - response is poor at low doses and takes longer for action.
- Recommendation is quickly titrating medication to maximum dose (in very low weight, or unborn expose to medication with therapeutic benefits)

- Be aware that certain medication, eg paracetamol or antibiotics may require pediatric doses according to liver function

- **Physical symptom relief:**
  - Abdominal cramps R/ Mebeverine 135mg tds, 20 mins before meals (smooth muscle relax) – not recommended - no evidence of safety in pregnancy!

    R/ Metoclopramide 5-10 mg tds, 20 mins before meals
  - Constipation R/ Fybogel – 1st line – must be given regularly/daily

    Lactulose – 2nd line - need plenty of fluids to be effective

Recommendations if active ED

In pregnancy:

- If BMI <18.5 - ideal weight gain between 12-18Kg
- Close monitoring of both nausea and vomiting; treat aggressively
- Monitoring macronutrients intake (usually less protein and fat)
- Monitoring micronutrient intake & recommend supplements:
  - ✓ Folic acid
  - ✓ Multivitamin and mineral with iron, Vit A, B and iodine – T/d
  - ✓ Vit D

Severe undernourished/purging (AN/PN)

- ✓Thiamine 100mg per day or 50mg qds
- ✓Vit B co-strong 1T tds
- ✓ Calcichew D3 Forte T bd
- ✓Dioralyte prn after purging (replaces K) or IV K+

Bulik, et al, 2009; Micali et al, 2007, 2009; Koubaa et al, 2005; Acosta and Treasure, 2015

Recommendation if active ED

In Breastfeeding:

- Way to lose weight or may be too preoccupied to breastfeed
- Need for additional 500-600Kcal/day to sustain breastfeeding
- Food restrictions may impact on milk quality (less volume and particular ↓fat content)
- Monitor micro and macronutrients

Recommend: - Mixed feeding

- HV monitor baby's growth and development

- ? Impact on child outcome (neurological development) and weight trajectory

Bulik, et al, 2009; Micali et al, 2007, 2009; Koubaa et al, 2005; Acosta and Treasure, 2015

Dos & Don'ts in EDs inc in perinatal period

Don'ts:

- Make shape or weight-related comments (e.g. "you look slim / thin", "you're getting big now", or "your bump is tiny/petite or big")
- If it's necessary to monitor weight, don't weigh the person when they're wearing shoes / heavy outer clothes
- Collude with ideas of "herbal supplements" being harmless, e.g., can still have laxative effect, maintain ED behaviours & cognitions
- Collude with irregular eating patterns, such as "intermittent fasting" - remind the importance of regular, balanced eating & sufficient dietary intake always and more in pregnancy

Do's:

- Normalise that body-related distress in perinatal period is likely to be greater in ED pts
- Remember underweight pts are also cognitively compromised (not just physically)
- Capitalise on motivation related to baby's wellbeing
- Recognise pregnancy symptoms can mask ED (e.g., nausea, vomiting, ↓ appetite, ↑ appetite, changes in food choices, ↑ trips to the bathroom post eating, shame in binging)
- Be sensitive to feelings of shame/stigma & perfectionism - disclosure
- For weighing: acknowledge challenge & offer "blind weighing"
- Use Motivational interview skills to work with the ambivalence (e.g. on one hand you are saying that you are scared to gain weight … on the other hand you want to have a healthy baby….)

Capacity assessment in EDs

Frequent decisions at stake:

- To refuse nutrition or nutritional support, eg NG feeding or assisted feeding
- To refuse admission to hospital
- To refuse medical treatment eg potassium replacement
- To take a medication

Is there a **reason** to suspect lack of capacity?

- **Severe emaciation & dehydration**
- **Refusing to eat**
- **Agitation and distress**
- **Low mood & hopelessness**
- **Suicidal thoughts**

Frequent inability to weigh risks and benefits due to:

- **Abnormal AN beliefs (I'm fat!, I wont die!, that is others not me)**
- **Irrational fear of food/weight gain**
- **Compulsion to restrict, purge, exercise etc... (I am in control!)**
- **AN - is identity**
- **Lack of insight (severity)**
- **Suicidal thoughts**

USE MHA

Anorexia nervosa is a disturbance of mind and impairment of brain

Capacity assessment (II)

- Usually unable to weigh up information due to the nature of AN in regards to decisions about food/weight gain:
  - Lack of insight (severety)
  - Abnormal AN beliefs (are fat!, wont die!, that is others not them)
  - Fear of weight gain
  - Compulsion to restrict, purge, exercise etc... (I am in control!)
  - AN can envelope identity

Lack of capacity for treatment decisions (admission and eating), despite frequently/always sounding reasonable and like having capacity!

Joint care – EDs, Perinatal and Maternity services (I)

If active ED and pt accepts referral to ED service:

- **EDS Treatment:** as per guidelines for treatment of EDs
  - Prioritise women in the perinatal period– 2 weeks assessment and 2 weeks for start treatment
  - treatment re-start post natal as soon as possible - 3-4 weeks PN
- **Perinatal service:** discuss AN/PN risks, monitor for co-morbidities and recommend psychopharmacological treatment

If active ED and pt declines referral to ED service:

- **Perinatal/maternity**: get specialist advice from local ED service and discuss sx/observations/investigation results, risks (physical and mental)
- **Perinatal/ED service recommend: regularity of examination/investigations:** weighing +blood investigations (to GP/obstetrician)
- **Referral**: specialist dietician
- **Perinatal**: Discuss AN/PN risks, monitor for co-morbidities and recommend psychopharmacological treatment
- **Psychiatric services**: MCA/MHA assessment – ED severity and risks

Joint care – EDs, Perinatal and Maternity services (II)

<u>If active ED and pt declines perinatal and ED referral</u>:

- **Maternity**: Liaise with Local ED and perinatal services + continue to offer referral to psychiatric services + monitor weight and mental state
- **Perinatal/ED service/GP**:
  - Share information on psychiatric history/risks with maternity
  - Recommendations for monitoring and treatment (mat/GP) + named obstetrician and caseload midwife (plus MH)
  - Recommend enhanced m/w care PN and specialist HV
- **Psychiatric services:** MCA/MHA assessments - severity and risks
- Maintain GP informed ? Children services

<u>If inactive ED:</u>

- Maternity and perinatal to monitor for signs of relapse - early referral for EDS for treatment
- Maternity: regular weighing, bloods every T and growth scans
- Perinatal: Discuss AN/PN risks
- Perinatal: Recommend enhanced m/w care PN and specialist HV

Role of perinatal service – inpatient setting (non ED)

If active ED:

- **Setting depends on:** BMI, physical exam, Risks (physical and mental), blood results
- Under MCA/MHA – insight, capacity to consent to treatment, ED severity/risks
- **ED Treatment:** provided/guided by local ED service
  - as per NICE guidelines for treatment of EDs
  - Psychological – ED prioritises women in the perinatal period– 2 weeks assessment and 2 weeks for start treatment
  - Treatment re-start post natal as soon as possible - 3-4 weeks PN
  - Feeding: Dietitian referral, meal plans (depending on BMI, food intake prior to admission)
  - Exercise and toilet supervision (30min after meals)
  - OT referral (skills for shopping food, cooking, going out to eat…)
- **Perinatal service:**
  - discuss AN/PN risks
  - monitor for co-morbidities and treat as usual
  - recommend psychopharmacological treatment

Learning Points

- Eating disorders are the psychiatric illnesses with highest mortality, 50% by suicide in AN. Same is true for mortality in the perinatal period.

- Eating disorders can affect fertility but unexpected pregnancies can occur.
- They can negatively impact pregnancy outcomes and even though frequently there is remission during pregnancy, relapse is frequent in the postnatal period.

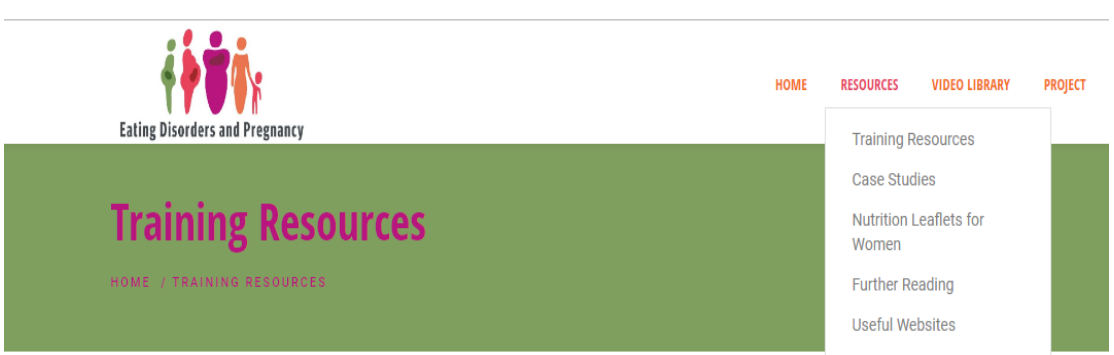
- Eating disorder should be regularly screened during perinatal period, particularly if there are concerns about weight gain and abnormal gastrointestinal symptoms.

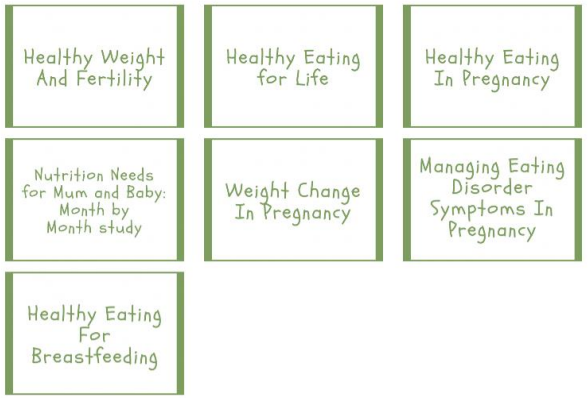
- Untreated mental illness in pregnancy can impact child health, growth and development.
- Eating disorders are difficult to treat and treatments are only moderately effective; therefore early intervention is essential for better prognosis and outcomes. Pre-conception advice by perinatal services.

- Management depends on severity and risk factors and should be, whenever possible, administered by specialist ED services. Pregnant/PN women being prioritised
- Psychological treatments are still the treatments of choice at present.

Online resources for Women with ED in perinatal period

- http://www.eatingdisordersandpregnancy.co.uk/





- https://www.babycentre.co.uk/a1042906/eating-disorders-in-pregnancy

- https://www.eatingdisorderhope.com/treatment-for-eating-disorders/special-issues/pregnancy/body-image-nutrition-change-coping

- www.b-eat.co.uk/HelpandSupport

Reading recommendations for patients and carers

For Bulimia and Binge Eating:

- Getting Better Bit(e) by Bit(e): A Survival Kit for Sufferers of Bulimia Nervosa and Binge Eating Disorder ***by Ulrike Schmidt & Janet Treasure***
- Overcoming Binge Eating ***by Christopher G Fairburn***
- Bulimia Nervosa: A Cognitive Therapy Programme for Clients ***by Myra Cooper, Gillian Todd & Adrian Wells***

For Anorexia:

- Anorexia Nervosa: A Survival Guide for Families, Friends and Sufferers ***by Janet Treasure***

For All diagnoses or EDNOS (Eating Disorder Not Otherwise Specified):

- Beating Your Eating Disorder: A Cognitive-Behavioural Self-Help Guide for Adult Sufferers and their Carers ***by Glenn Waller, Victoria Mountford, Rachel Lawson and Emma Gray***

For Carers:

- Sills-based Learning for Caring for a Loved One with an Eating Disorder: The New Maudsley Model **by Janet Treasure, Grainne Smith & Anne Crane.**
- Anorexia Nervosa: A Survival Guide for Families, Friends and Sufferers **by Janet Treasure**

Questions?

Thank you!

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