EATING DISORDERS & POSTPARTUM MENTAL HEALTH:

Staying Connected to Self and Recovery

Angela Kaloudis, LMHC, PMH-C
Clinical Training Specialist
The Renfrew Center

AGENDA

To describe **the connection between eating disorders and Perinatal Mood and Anxiety Disorders** (**PMADs**) during the postpartum period

To describe the benefits of **continued eating disorder and PMAD assessment** up to a year postpartum

To learn appropriate **treatment goals and interventions** for individuals with eating disorders during the postpartum period

WHEN YOU THINK OF EATING DISORDERS, WHO DO YOU PICTURE? WHO DO YOU SCREEN?

EATING DISORDER OR DISORDERED EATING?

WELLNESS

- Mostly positive feelings about body shape/size
- No “good” or “bad” foods
- Regular moderate exercise, but can take time off
- Can take care of their body despite feelings of it
- Food as nourishment, pleasure, social connection, culture, comfort, & celebration.

Preoccupation with body shape, size & food

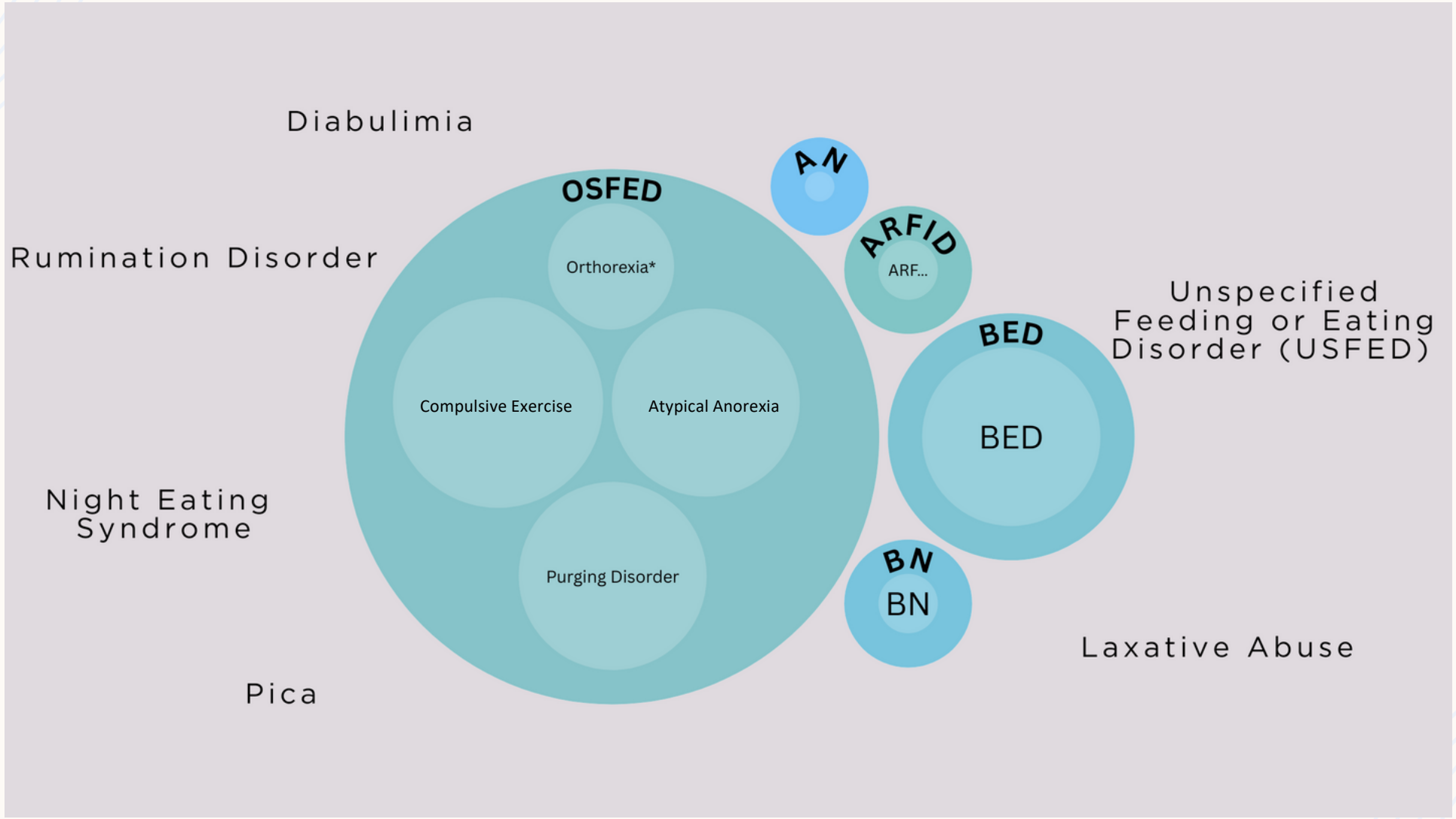
- Dislikes certain body parts or has a consistent desire to lose a few pounds
- Weighs self daily but unsure why
- Frequent thinking about food, eating and body
- Sometimes feel guilty or bad for eating and may “make up for it”

Distress about body shape, size & food

- Thoughts about food, eating and body interferes with daily activities
- Rigidity in eating
- Compensates for eating (e.g., vomiting, fasting, over-exercising)

Eating Disorders

- Anorexia Nervosa
- Bulimia Nervosa
- Binge Eating Disorder
- Other Specified Feeding or Eating Disorder (OSFED)
- ARFID


Diabulimia
Rumination Disorder
Night Eating Syndrome
Pica
OSFED
Orthorexia*
Compulsive Exercise
Atypical Anorexia
Purging Disorder
AN
ARFID
ARF...
BED
BED
BN
BN
Unspecified Feeding or Eating Disorder (USFED)
Laxative Abuse

SYSTEMIC ISSUES & RISK FACTORS

- Diet Culture
- The “Thin Ideal”
- Wellness Culture & Healthism
- Fatphobia / Anti-Fat Bias
- Weight Discrimination & Weight Stigma
- Marginalization & other Oppressive forces
- Poverty & Food Insecurity
- Provider biases, lack of awareness & education
- Inequities in Care

THE PERINATAL PERIOD

Conception

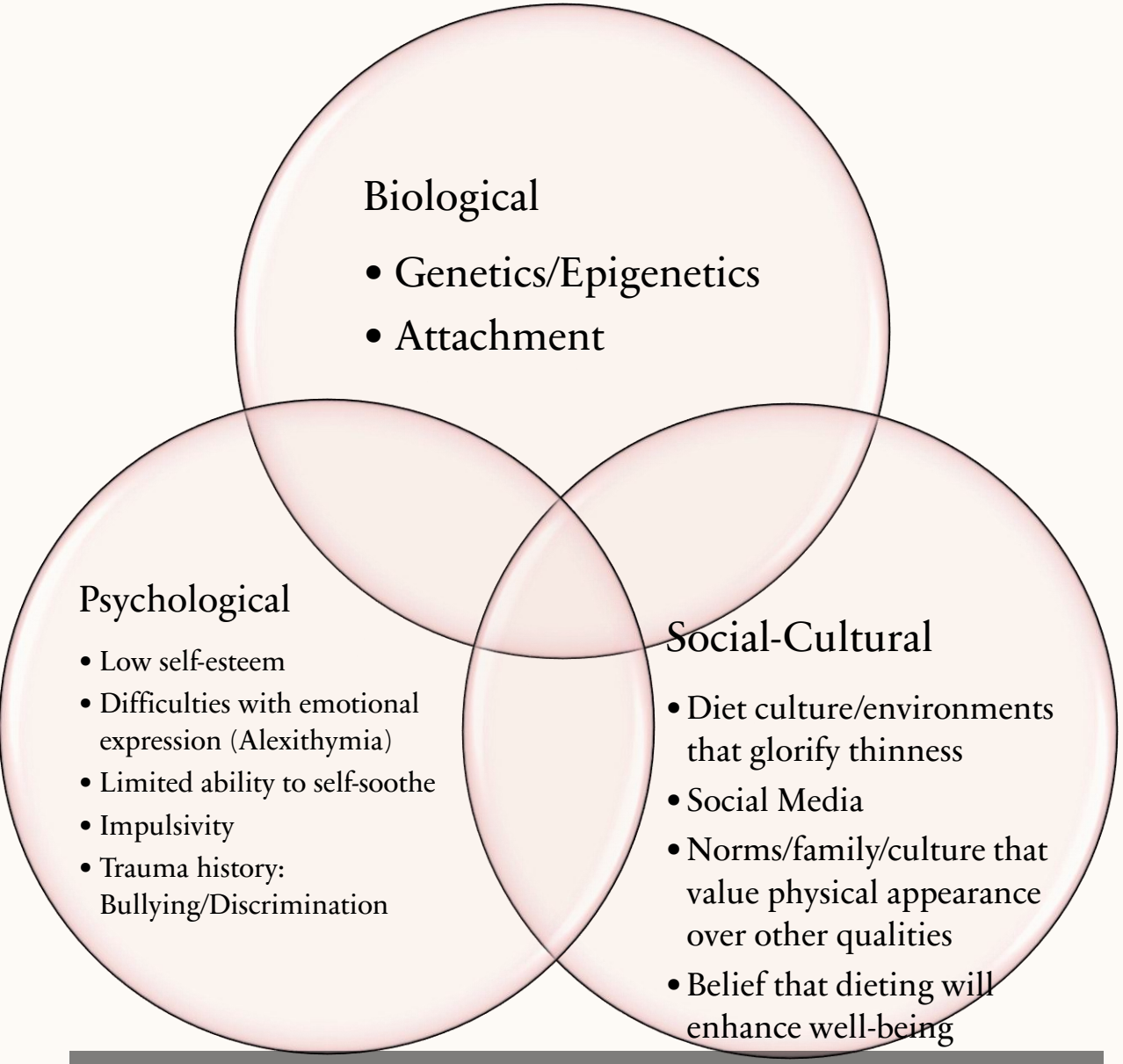
- Attention to Infertility
- Attention to unplanned pregnancies

Pregnancy

- Physical Changes
- Psychological Changes
- Relationship changes
- Medical avoidance and anxiety
- Weight bias/stigma from friends, medical professionals, family
- Increase in doctor visits

Postpartum

- Transition To Parenthood
- Decrease in medical visits
- Weight Stigma and other (many) societal pressures



EATING DISORDERS

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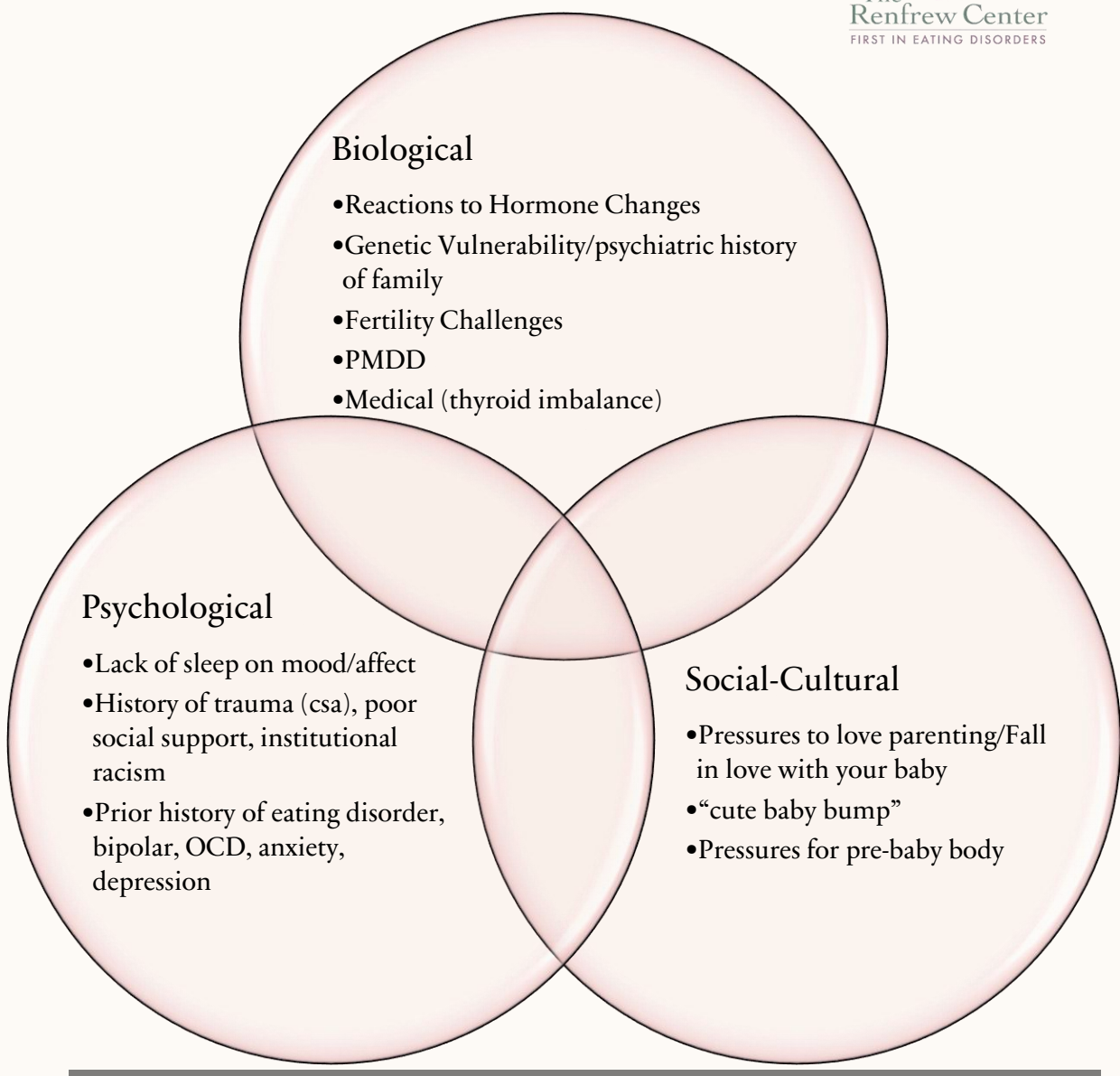


PMAD

THE FACTS:
BODY CHANGES, LIFE CHANGES

- Universal screening does not exist for either population.
  - Eating Disorders place people at an increased risk for PMAD
  - PMAD impacts 22% of the population
  - ED impact on fertility is largely unknown though overlap exists
- Eating disorders affect ~30M people in the US (ANAD)
  - Anorexia Nervosa
  - Bulimia Nervosa
  - Binge-Eating Disorder
  - Other Specified Feeding and Eating Disorder
  - Avoidant and Restrictive Food Intake Disorder
- High rates of miscarriages/ pregnancy complications and adverse affects to birthing parent with an eating disorder
- BIPOC with EDs are half as likely to be diagnosed
- People in larger bodies are half as likely to be diagnosed with an eating disorder and are stigmatized within the healthcare system. High rates of medical appointment avoidance, less honesty about behaviors. Less likely to be asked/assessed

FROM CONCEPTION

- We have:

People in sustained recovery who have desired to get pregnant and may struggle with fertility issues (or not)

People who are active in an eating disorder and become pregnant either intentionally or unintentionally (Daigle, K. B. 2020)

- Not all pregnancies are planned, pts with EDs become pregnant unintentionally at 2x the rate
- Conflicted feelings due to possible infertility struggles
- Established care, seen bi-weekly, and then weekly after 35 weeks (non high-risk)
- Weighed at every appointment*
- "Pregorexia"
- If pregnancy sustained → Water retention, Hunger/fullness cues, exhaustion, breathlessness, acid reflux, morning sickness
- Body changes/may not "look" pregnant or may look "too pregnant" ("are there twins in there?")

Dörsam ,2019; Easter,2013; Martínez-Olcina, 2020

Perinatal Mood and Anxiety Disorders

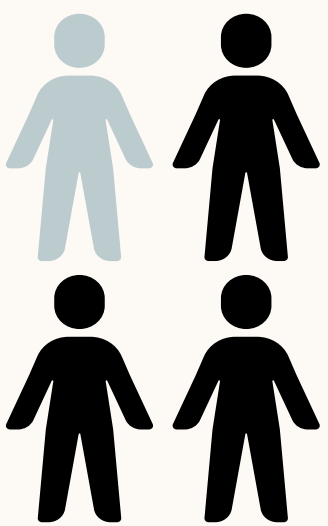
Research shows that Perinatal Mood and Anxiety Disorders can appear during pregnancy and up to a year after birth. (Postpartum Support International, 2014).

Priorities:

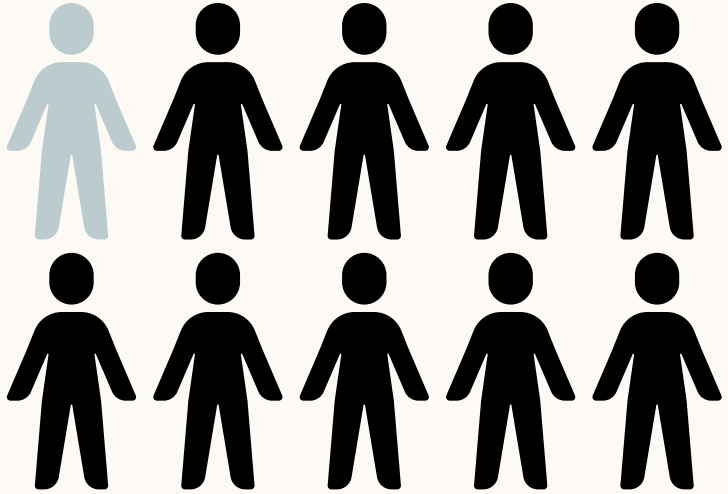
Early Identification

Postpartum Support Planning

Frequent Screening



1 in 5-7 moms* suffer from Postpartum depression.



1 in 10 dads suffer from Postpartum Depression

(Paulson & Bazemore, JAMA 2010)

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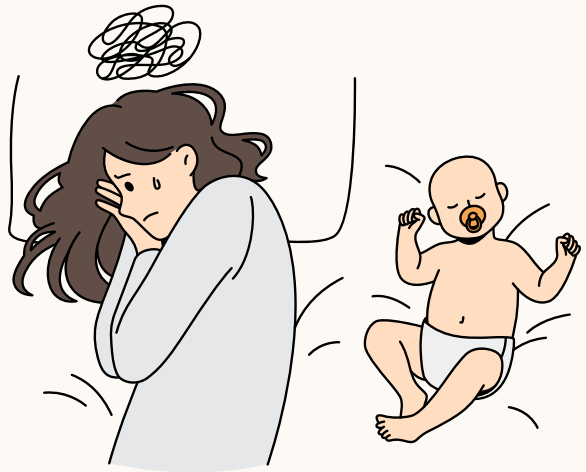
Under Pressure

POSTPARTUM PRESSURES

Bounce back culture	Loss of bodily autonomy	Carrying the Mental load	Functioning with lack of sleep	Breastfeeding/Feeding issues
Choosing to return to work (or not)	Need to be enamored and in love with the baby	To be healed by 6-weeks postpartum	Pressure to keep feelings inside	Internal Pressure of competing identities • Eating Disorder Identity vs New Parent Identity

Postpartum issues we don't talk about



- Identity Issues/loss of self
- Loneliness
- Resentment/anger towards partner
- Intrusive Thoughts
- Birth Trauma

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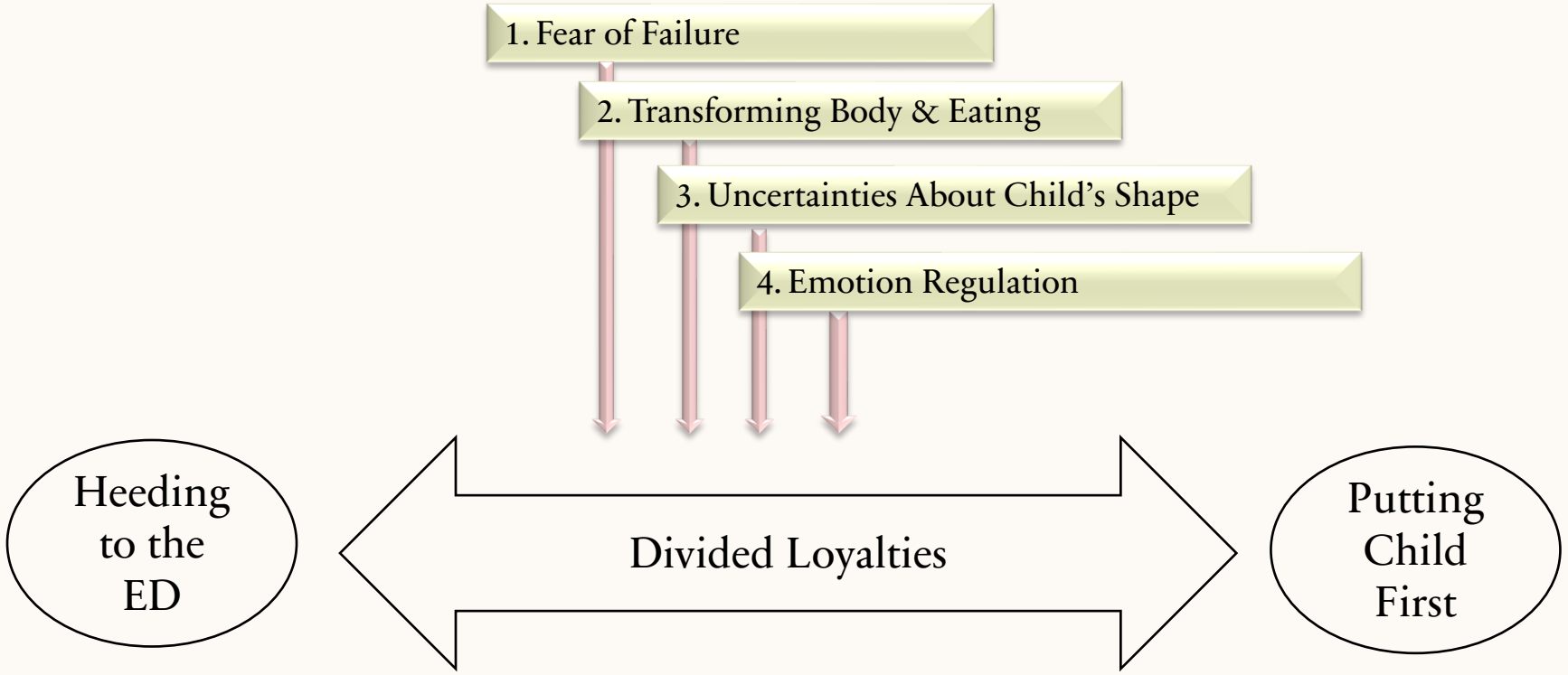
WHAT IS THE PULL? WHY IS THIS SO TOUGH?



Note: Adapted From "Treading the tightrope between motherhood and an eating disorder: A qualitative study," by S. Tierney, J.R.E. Fox, C. Butterfield, E. Stringer, and C. Furber, 2011, *International Journal of Nursing Studies*, 48. p. 1227. Copyright 2011 by Elsevier.

Perinatal Mood and Anxiety Disorders (not just PPD)

Baby Blues

- The non-disorder. 60-80% of new mothers experience mood swings and weepiness during the first two weeks after giving birth. (PSI, 2014)

PPD

- Postpartum depression: Higher for those who experience poverty, food insecurity (which can lead to eating disorders); Higher for teen parents; Higher for high-risk individuals (those with eating disorders, prior depressive episodes/anxiety/OCD, prior miscarriages and/or stillbirth)

Postpartum PTSD

CSA and previous trauma to be assessed, birth trauma is fairly common

PPA

Postpartum Anxiety - Approximates 6% of pregnant women and 10% of postpartum women develop anxiety (PSI, 2014); Anxious thoughts about baby and wellbeing of the baby occur in 80-90% of recent postpartum individuals

PPP

Postpartum psychosis: 1-2 in 1000 deliveries. A medical emergency

POCD

- Postpartum OCD

A strong level of evidence supports the association between disordered eating and depressive and anxiety symptoms during pregnancy and postpartum

Mischoulon, D. et al. (2011)
Baskin & Galligan (2019)

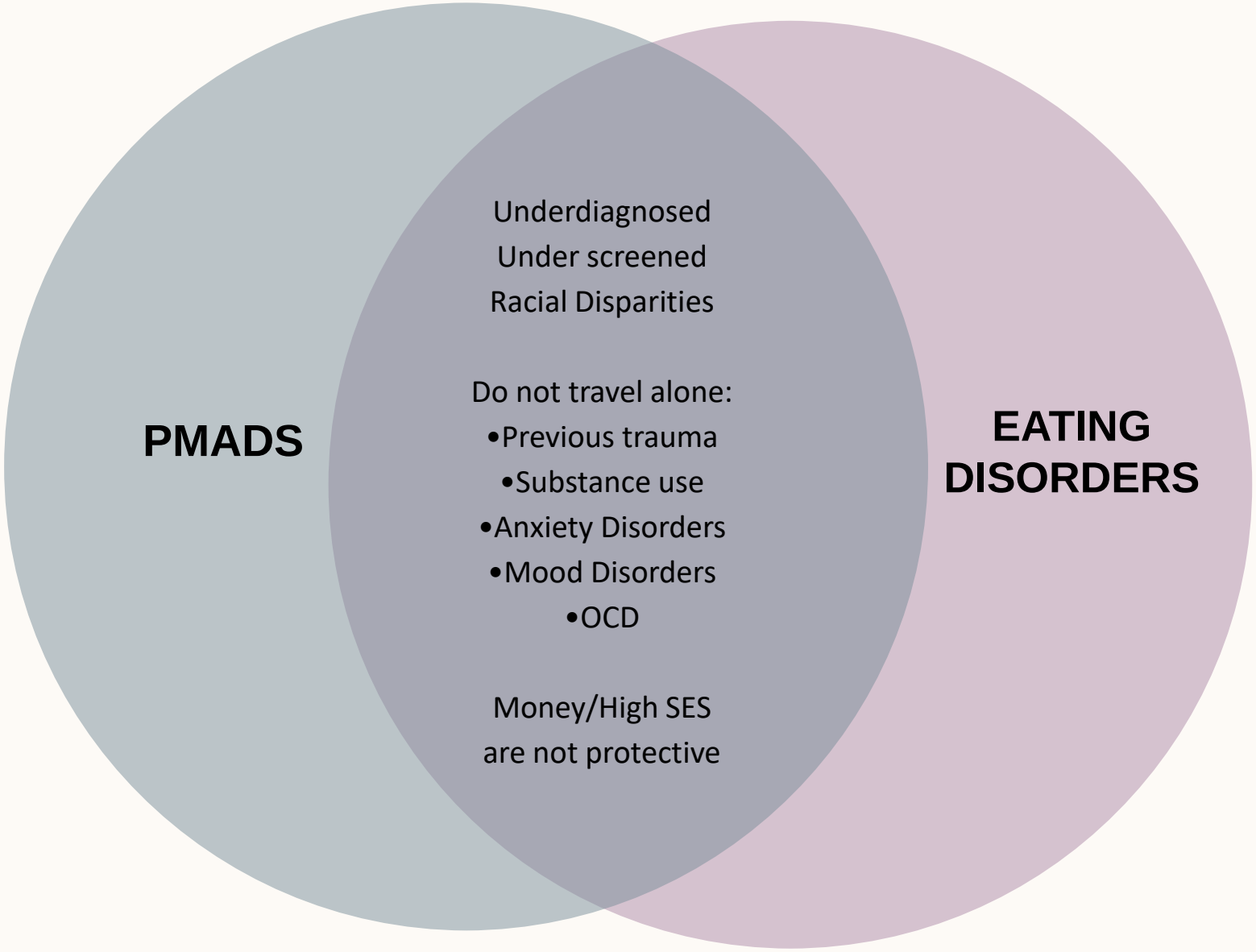
Eating Disorders are emotional disorders

Eating Disorders rarely travel alone

- **Major Depressive Disorder** is one of the most common mental health diagnoses to co-occur with eating disorders

- A study of more than 2400 individuals hospitalized for an eating disorder found that 97% had one or more co-occurring conditions, including:
  - 94% had co-occurring mood disorders, mostly major depression
  - 56% were diagnosed with anxiety disorder
  - 20% had obsessive-compulsive disorder
  - 22% had post-traumatic stress disorder
  - 22% had an alcohol or substance use disorder

Perinatal Mood and Anxiety Disorders and Eating Disorders have been identified in (people) of every culture, gender, weight, age, income level and ethnicity.



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ANOREXIA & PERINATAL PERIOD

- 6x greater risk of fetal mortality for pregnant women with Anorexia
- 22% relapse rate during pregnancy
- Delayed diagnosis in higher weight clients
- Higher rates of Hyperemesis gravidarium
  - Thromboembolic disease
  - Growth/differentiation factor 15 (GDF15)
  - Alteration of serotonin (5-HT) system

  (Terävä-Utti, E., Nurmi, M., 2024)
- Fetal Growth Restriction
- 2/3 relapse 6-9 Months Postpartum
- 40% comorbid affective disorder
- 90% show mother-child bonding problems

(Sebstani et al., *Frontiers in pediatrics* 2020)

EATING DISORDERS AS A RISK FACTOR

90% of women with a history of an eating disorder reported problems regarding their adjustment at 3 months postpartum (includes bonding), compared with 13% of women who had not had an eating disorder. (Fogarty et al., 2018; Daigle K.B. 2020.)

67% of pregnant people (N=24) relapsed on their ED during pregnancy & 50% relapsed within a year of delivery, all of whom had postpartum depression

4 had low birth weight infants. Among the participants who did not have postpartum depression, there were no low-body-weight infants. (Makino, M., Yasushi, M. & Tsutsui, S. 2020).

Individuals with BED are at risk for higher birth weight babies because of insulin increasing growth hormones

Individuals with AN risk IUGR, 6x greater risk of fetal mortality, premature delivery, low birth weight babies and other risks due to malnourishment (Sebstani et al., *Frontiers in pediatrics* 2020)

Everyone with an eating disorder needs to be screened frequently during the perinatal period

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The risk of ED relapse in the postpartum period is up to 70% for those that went into remission in pregnancy

(Micali, N. Simonoff, E. & Treasure, J. 2011)

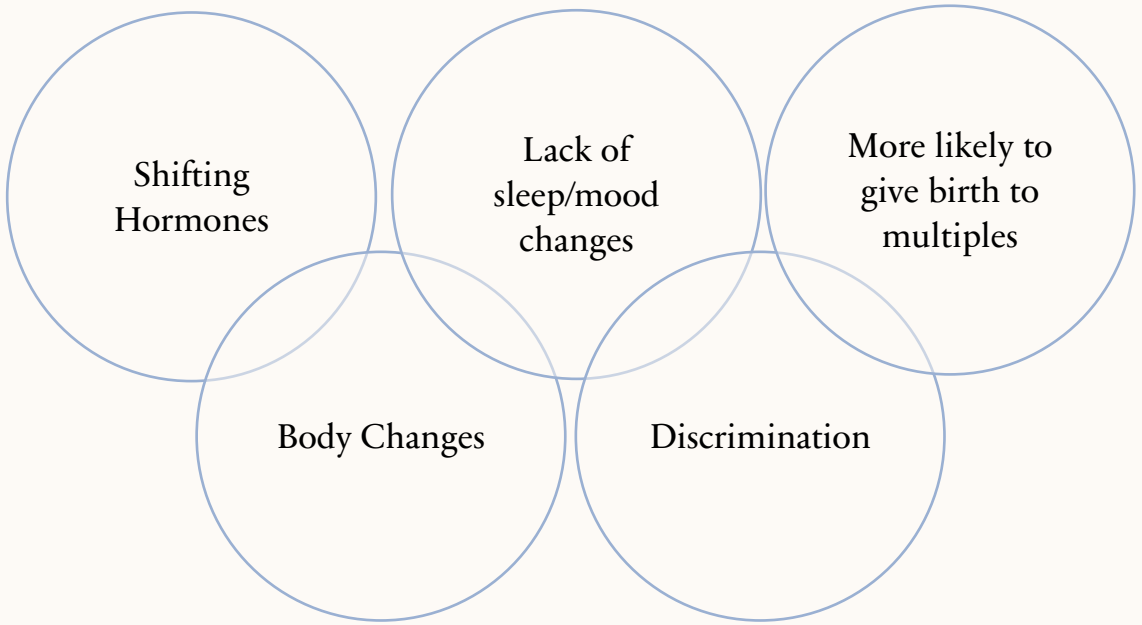
WARNING SIGNS DURING PREGNANCY & POSTPARTUM FOR ED

- Severe depression
- Avoidance
- Anxiety/panic attacks
- Low self-esteem
- Poor body image
- Isolation, relationship disconnection
- Suicidal ideations
- Distress around weight gain, body changes
- Emergence of compensatory-for-eating behaviors
- Hyperfocus on weight loss
- Difficulty connecting to baby, attachment
- Preoccupation with food, obsessive with “clean eating”
- Isolation from loved ones, social activities
- Lack of social media literacy

NOT JUST IMPACTING CISGENDER HETEROSEXUAL WOMEN

- The risk of experiencing a Perinatal Mood and Anxiety Disorder (PMAD) are higher with co-occurring eating disorder, as well as poor self-esteem and body image.
- Rates are higher within LGBTQIA and other intersecting identities.
- LGBTQIA+/gender diverse clients are at a greater risk for eating disorders AND transgender parents are **3x** more likely to suffer from perinatal anxiety
  - LGBTQIA+ have higher rates of eating disorder behaviors than their cisgender and heterosexual peers and using fertility treatments
  - More likely to experience emergency C-section and birth trauma
  - Lesbian / Queer birthing people in the postpartum period reported a higher prevalence of PMADs and increased rates attempting/considering suicide.

Maccio & Pangburn, 2011; Floss 2005



Black mothers are **4x** more likely to die than white mothers.

COMMUNITIES OF COLOR – HEALTH DISPARITIES

- Black women are 3-4x more likely to die from pregnancy-related causes than white women. **And most pregnancy-related deaths in Black women are preventable**
- 2x more likely to experience a PMAD (Policy Center Maternal Mental Health, 2023)
- Birthing People Of Color may have less support with infant care at home than white birthing people
- Birthing People Of Color are more likely to experience birth trauma than white birthing people
  - When working with Black doctors, rates decreased. (2020)
- Black people are 50% less likely to be diagnosed with an eating disorder and less likely to receive treatment, despite similar presentation

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ENGAGING THE AUDIENCE

- Make eye contact with your audience to create a sense of intimacy and involvement
- Weave relatable stories into your presentation using narratives that make your message memorable and impactful
- Encourage questions and provide thoughtful responses to enhance audience participation
- Use live polls or surveys to gather audience opinions, promoting engagement and making sure the audience feel involved

SCREENING & INTERVENTIONS

SCREENING FOR EATING DISORDERS

Thinking pattern, preoccupation of body concerns after baby

Severity of ED symptomology

Safety concerns and the client's internal and external resources

Assess rigidity in patterns of behavior

History of ED and treatment (early intervention is best)

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QUESTIONS TO CONSIDER

Are you allowing yourself to nourish your hunger?	Can you walk me through mealtimes at home? How often do you eat throughout the day?	Do you stop eating because you think you should (opposed to because your body is satisfied)?	Do you make food choices based on foods you enjoy?
Do you compensate after you eat with exercise, laxatives, diet pills, or vomiting?	Do you become physically uncomfortable (such as weak, tired, dizzy, a headache) throughout the day?	Do you feel that your food selections include all foods?	Do you have to eat in a certain pattern – e.g., eating food in a particular order or always at certain times of the day?

CLINICAL TIPS FOR EATING DISORDERS…

- Body checking and weight preoccupation is common for most eating disorders
- Check bias! BED is not the opposite of Anorexia
- Eating disorders can present differently at different times for the same individuals. A person can shift amongst different diagnoses.
- "Symptom swapping" – this can happen during any transition, common for the eating disorder to come back even more severe postpartum
- Assess emotions related to exercise
- Hunger/fullness may be off – we can not count on this
- Recommendations for ED populations with PMAD may be different due to not wanting to increase ED behaviors
- The birthing parent's mood and anxiety symptoms have a direct impact on [their] partner as well. The partner may feel overwhelmed, confused, angry, and afraid they will never be well. This may place a strain on the couple's relationship.

RED FLAGS

Only feeding baby, forgetting to eat, denying physical cues	Binges increase	Consumed with thoughts related to body size, losing weight, unhealthy obsession with exercising	Frequent “body checking” in mirror	Self-worth: Am I going to still be loveable In this body?
Thinking about food? Worried about food? Food surveillance	Trying on “pre-baby” clothes	Breastfeeding complications, compulsive need to breastfeed/donate milk	Hiding body with clothes (ex: wearing baggy clothes, changing multiple times)	Drinking excessive amounts of water, chewing gum, eating mints
	Loss of control around food; “I can’t trust myself”	Avoiding eating in front of others/excuses for not eating	Becoming socially isolated, avoiding peers	

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CELEBRATING 35 YEARS

ASSESSMENT

Individuals may develop ED issues **during or AFTER** pregnancy

Asking specific questions about eating, exercise, "morning" sickness, and body image

Involving loved one's in therapy which may provide additional information

Communicating with medical providers to obtain information

Ask about social media usage

968 FELLOWS OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

- Less than ½ asses for ED, body image concerns, weight related cosmetic surgery, binging or purging.
- Approximately 91% of Generalists agreed the ED can negatively effect pregnancy outcomes
- 90% were aware ED were associated with Postpartum Depression and Low Birth weight.
- Only 54% felt that assessing for ED was in their "Purview"

Journal of Womens Health, 2009

SUPPORTING NEW PARENTS IN THEIR RECOVERY

- Early Intervention
- Check own clinician bias & transference/countertransference
  - Supervision for clinicians is a must!
- Try not to fall into the "don't ask, don't tell" trap
- Ask about intrusive thoughts, feeding anxieties (for themselves and the baby)
- Usually longing for a pre-pregnancy body = longing for pre-pregnancy life
- Therapeutic Connection and attachment
  - As relational connection increases, eating disorder symptomology decreases
- Postpartum Support Plan

Evidenced Based Treatments for PMAD and ED

Exposure and Response Prevention

AN/restrictive patterns, POCD

Unified Protocol

Transdiagnostic CBT

UT for Eating Disorders & Comorbidity

DBT

CBT

All EDs

PPD & PPA

Motivational Interviewing

Interpersonal Therapy (IPT & IPT-P)

Binge-Eating in OP settings

Effective for PMADs, Postnatal Depression

Medication*

Peer Support

Somatic Therapy

- Perinatal Psychiatrist
- Support people and groups
- ED Therapist
- *Doula*
- **Care Team**
- Lactation Consultant*
- OB/GYN or Midwife
- Registered Dietitian
- Pelvic Floor Therapist*

***Birthing people and their partners who work with doulas have better outcomes.**

***For Black individuals, even more of a critical difference**

ASSESSMENT TOOLS

Screening and early intervention can protect the well-being of the mother, baby and entire family

- **PHQ-9***
- **Edinburgh Postnatal Depressive Scale (EPDS) ***
  - Designed for postpartum, however can be used perinatally
- Bipolar Screening: Mood Disorder Questionnaire (MDQ)
- GAD-7*
- C-SSRS (For suicidal thoughts)
- PCL-5 for PTSD symptoms
- **EDE-Q**
  - Diagnostic Fluctuation
  - Screen 1x/month (every 28 days)

*Thoroughly validated and can be used for partners too

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SOME LAST WORDS:

Early Intervention is Essential!

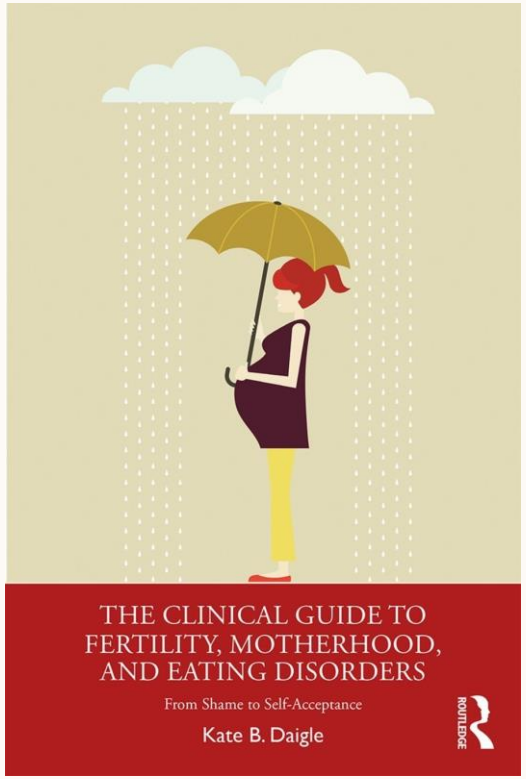
- Reduce overall prevalence of perinatal mood and anxiety disorders and increase rates of remission/treatment response
- Practicing from an anti-diet, fat-positive, anti-fat bias lens is critical

Improve outcomes by:

- Family Support during critical transition into parenthood
- Help identify common triggers during perinatal period and offer support, tools as needed.
- Ask about comments from others about changing body, identify changes, lack of sleep, mental health stressors Individual and family care, continuity of care through perinatal period and beyond

RESOURCES:

- Postpartum Support International: **https://www.postpartum.net/**
- The Clinical Guide to Fertility, Motherhood, and Eating Disorders – Kate B. Daigle
- Good Moms have Scary Thoughts – Karen Kleiman & Molly McIntyre
- ANAD
- The Renfrew Center
- 2020mom
- La Leche League
- MGH maternal consultation rounds
- Medications while breastfeeding: **https://mothertobaby.org**
- …and for your own continued unlearning:
  - *My body is Not an Apology – Sonya Renee Taylor*
  - *What We Don't Talk About When We Talk About Fat – Aubrey Gordon*
  - *Reclaiming Body Trust – Hilary Kinavey and Dana Sturtevant*
  - *Fat talk: Parenting in the age of diet culture – Virginia Sole-Smith*



REFERENCES

- Daigle, Kate B. The Clinical Guide to Fertility, Motherhood, and Eating Disorders: From Shame to Self-Acceptance. Routledge, 2020.
- Makino M, Yasushi M, Tsutsui S. The risk of eating disorder relapse during pregnancy and after delivery and postpartum depression among women recovered from eating disorders. BMC Pregnancy Childbirth. 2020 May 27;20(1):323. doi: 10.1186/s12884-020-03006-7.
- Johansen, Stenhaug, B. A., Robakis, T. K., Williams, K. E., & Cullen, M. R. (2020). Past Psychiatric Conditions as Risk Factors for Postpartum Depression: A Nationwide Cohort Study. The Journal of Clinical Psychiatry, 81(1). https://doi.org/10.4088/JCP.19m12929 Kapa, Litteral, J. L., Keim, S. A., Jackson, J.
- L., Schofield, K. A., & Crerand, C. E. (2022). Body Image Dissatisfaction, Breastfeeding Experiences, and Self-Efficacy in Postpartum Women with and Without Eating Disorder Symptoms. Journal of Human Lactation, 8903344221076529–8903344221076529. https://doi.org/10.1177/08903344221076529
- Mischoulon, D. et al. (2011). Depression and eating disorders: treatment and course. Journal of Affective Disorders, 130.
- Fogarty, Elmir, R., Hay, P., & Schmied, V. (2018). The experience of women with an eating disorder in the perinatal period: a meta-ethnographic study. BMC Pregnancy and Childbirth, 18(1), 121–121. https://doi.org/10.1186/s12884-018-1762-9
- Chua, Lewis, G., Easter, A., Lewis, G., & Solmi, F. (2020). Eighteen-year trajectories of depressive symptoms in mothers with a lifetime eating disorder: findings from the ALSPAC cohort. British Journal of Psychiatry, 216(2), 90–96. https://doi.org/10.1192/bjp.2019.89
- The National Eating Disorders Assocation (2015). Pregnancy and Eating Disorders: A Professional's Guide to Assessment and Referral. https://nedc.com.au/assets/NEDC-Resources/NEDC-Resource-Pregnancy.pdf
- Breland, J. Y.; Donalson, R.; Dinh, J. V.; and Maguen, S. (2018). Trauma exposure and disordered eating: A qualitative study. Women & Health, 58(2), 160–174. https://doi.org/10.1080/03630242.2017.1282398.
- Tagay, S.; Schlottbohm, E.; Reyes-Rodriguez, M. L.; Repic, N.; and Senf, W. (2014). Eating disorders, trauma, PTSD, and psychosocial resources. Eating Disorders, 22(1), 33–49. https://doi.org/10.1080/10640266.2014.857517.

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