NATIONAL CURRICULUM IN REPRODUCTIVE PSYCHIATRY

Eating Disorders

Progressive Case Conference: Eating Disorders Across the Perinatal Period

Trainee Guide

Contributors
Jyoti Sachdeva, MD
Neeta Shenai, MD
Joy Moel, PhD

Pre-Reading

Before attending the classroom didactics on this module, please review some basic concepts around eating disorders by reading the following articles:

1) Kimmel MC, Ferguson EH, Zerwas S, Bulik CM, Meltzer-Brody S. Obstetric and gynecologic problems associated with eating disorders. International Journal of Eating Disorders 2016 March;49(3):260-75

2) 2. Claydon EA, Davidov DM, Zulling KJ, Lily CL, Cottrell L, Zerwas SC. Waking up everyday in a body that is not yours: a qualitative research inquiry into the intersection between eating disorders and pregnancy. BMC Pregnancy and Childbirth 2018.November 29, 18 (1): 463-76

Session Overview

- Eating Disorders During Pregnancy - Clinical Challenges - Case Part 1
- Treatment Challenges – Case Part 2
- Eating Disorders - Postpartum Challenges – Case Part 3

Learning Objectives

By the end of session, the learner will be able to:

1) Understand unique clinical challenges that come up in pregnancy in women with eating disorders.
2) Learn to assess maternal and fetal risks posed by active eating disorder in pregnancy and formulate a treatment plan.
3) Recognize clinical challenges in the postpartum course of women with eating disorders.

Introduction

- At least 5% of women have an eating disorder (ED) during pregnancy.
- Order of eating disorder prevalence in pregnancy is- Pica> Binge eating disorder (BED) >Bulimia Nervosa(BN) > Anorexia Nervosa (AN).

- Eating disorders in pregnancy are often associated with anxiety and depression. Significant comorbidity with - Major depressive disorder (MDD), Generalized anxiety disorder (GAD), Obsessive compulsive disorder (OCD) and Post traumatic stress disorder (PTSD).
- The perinatal time is a period of transitions on multiple levels and must be recognized as a time of tremendous vulnerability for women with eating disorders. There is significant risk for illness exacerbation during pregnancy and postpartum.
- Development or worsening of eating disorders in pregnancy and postpartum is associated with poor outcomes for both mother and the baby.
- Many women with eating disorder may not disclose symptoms to their obstetrician for fear of judgment and stigmatization, thereby increasing the risk of pregnancy related complications.
- Treatment needs a multidisciplinary approach focusing on educating women about the expected physical and physiological changes of pregnancy; helping the women cope with transitions and challenges of parenthood; addressing self-esteem and trauma history in therapy.

Case Presentation Part 1: Case Vignette

Lauren, a 28-year-old married Caucasian female G1P0A0, currently at 25-weeks gestation, comes in for initial psychiatric evaluation. She has been on extended medical leave from her graduate psychology program secondary to mental health issues and wishes to return soon. Her obstetrician has referred her for an evaluation as patient has history of eating disorder and is not gaining weight appropriately in pregnancy.

History of Present Illness

Patient reports onset of emotional struggles around age 12. Her mother was physically and emotionally abusive, parents' had much ongoing marital discord and academic pressures at school were increasing. She was also cross -country captain at school and continued success in this sport was extremely important to her. Life was beginning to feel out of control and she felt overwhelmed. Around age 13, she started restricting junk food as she felt that she would run faster if she ate healthy foods and lost weight.

Over the next year, this gradually spiraled out of control with excessive focus on calorie counting and escalated to restricting. She also started running 6-10 miles daily to control her weight. Over the next few years, her symptoms worsened progressively and by age 15, she had lost weight down to 80 pounds. By this time, eating and weight had become focal points of her existence as they provided her with a sense of control over her life, and she gradually became intensely fearful of gaining weight. She also became extremely self-conscious about body image and any weight gain was associated with a severe sense of worthlessness. To improve her sense of self-worth, she put all her energy into academic success at school. She graduated high school with a high GPA.

Menarche was delayed until age 16. At age 16, her parents recognized her restricting and brought her to treatment. Patient had no insight into her symptoms at that time and did not wish to engage in treatment and was poorly complaint with it.

During freshman year of college, she turned to binge eating and purging (in place of running) to control weight. Purging was mainly via self-induced vomiting, though she attempted to use laxatives a few times. She would purge 6-8 times daily. She also started using purging as a way to release stress as she noticed depression at this time. She had symptoms of persistent sad mood, low energy, hopelessness, and

suicidal thoughts. “Feeling fat” made her feel very depressed and she would punch herself in areas which “felt fat”. Her symptoms continued to worsen and finally led to a suicide attempt via an ibuprofen overdose. She was hospitalized and started on Escitalopram which helped some with her eating disorder symptoms and her mood.

Since then, she has had persistent low level of sadness along with chronic poor self-esteem, poor energy and concentration. She has had episodic worsening of depression on top of her baseline low mood.

Her symptoms again worsened after a sexual assault in 2014. She became severely depressed and stopped eating, hoping to die by starving herself. 3 months after the assault, she started having symptoms of nightmares and flashbacks of the assault, hyper-vigilance and avoidance of any triggers that brought back memory of the assault. She sought -Eye movement desensitization and reprocessing (EMDR) treatment, which was somewhat helpful. She still tends to have a recurrence of nightmares, flashbacks, insomnia, panic attacks and depressed mood every year around the anniversary of the assault.

She denies a history of social anxiety, obsessions or compulsions, cutting, mania, or psychosis.

In the past, she used alcohol socially, none since pregnancy. Denies history of problem drinking, illicit drug use or cigarette smoking

After years of psychiatric treatment, she started improving in graduate school and was able to stop purging on a daily basis as she finally recognized the harmful effects of this. The eating disorder is, “always just under the surface” and she continues to struggle with intense fear of weight gain. Her self -worth is still very much driven by her weight and at times of high stress, she briefly relapses into restricting or purging.

She has always had ambivalence about pregnancy as the thought of weight gain made her very apprehensive. Her periods have always been irregular and the pregnancy was unplanned and a surprise. As abortion is against her religious views, she decided to continue with pregnancy. At the time she became pregnant, the eating disorder was in partial remission and her weight was in normal range. She is 5ft 1inch tall and her pre-pregnancy weight was 104 pounds with a Body Mass Index (BMI) of 19.6.

Pregnancy has been challenging because of severe hyperemesis and she had rapid weight loss of 10 pounds in the 1st trimester. After first trimester, as the nausea receded, she was able to gain some weight but that brought intense anxiety.

Through the pregnancy, she has been struggling with changes in her body. Every day, she feels like she is, “waking up in someone else’s body.” Pregnancy has felt very emotionally traumatic and she has not been able to experience much joy so far which further fills her with guilt. As her clothes feel tighter, she feels “fat” and is becoming increasingly more depressed. She has tried to punch her abdomen several times as it feels bigger. She has had an exacerbation of symptoms in terms of depressed mood, hopelessness, difficulty getting out of bed, severe anxiety. At her last prenatal visit, her OB commented on the need for appropriate weight gain, causing her to panic and restrict for one day. She also felt depressed and suicidal and considered acetaminophen overdose, but thoughts of the baby kept her safe. Suicidal thoughts have since resolved.

She is still restricting actively, though not to the same level as before. Her OB advised her to consume 2000 calories per day but she will not allow herself to go over 1500 calories per day. Over the past 7 weeks, she has also had 2 episodes of purging. She very much wants the baby though she does not feel very attached to her baby, at this point.

Discussion Questions (Clinical Challenges)

1) What menstrual cycle changes are unique to this population which make conception challenging?

2) How does the eating disorder change the experience of pregnancy?

3) What clinical challenges may come up due to eating disorder during pregnancy

Case Presentation Part 1 *continued*

Past Psychiatric History

Psychiatric Hospitalizations: Admitted twice in past, for intense restricting, depression and suicidal ideation / attempt. Admissions were approximately 2 weeks long and helpful. First admission was during her freshman year of college after an ibuprofen overdose. The second one was after the sexual assault in 2014. She also attended Eating disorder partial program for several weeks after the second hospitalization.

Past Outpatient Treatment: Several years of outpatient treatment off and on since age 16.

Past Diagnoses**:** Major depressive disorder, recurrent, moderate, Post traumatic stress disorder, Anorexia Nervosa, binge purging type

Psychotherapy: Has previously attended cognitive behavior therapy (CBT) for depression, eye movement desensitization and reprocessing (EMDR) for PTSD

Past medication trials:

1. Escitalopram 20 mg daily - effective and took for years
2. Transitioned to sertraline in 2017 secondary to worsening depression - discovered she was pregnant soon after and continued the sertraline given good pregnancy safety data.
3. Her depression continued to worsen through pregnancy and she was transitioned to fluoxetine 20 mg daily which she is taking and has been partially effective so far.
4. Took topiramate for some time as a teenager for migraines

Family Psychiatric History

Depression - Mother (on venlafaxine with good response)
Anxiety - Mother (on venlafaxine)
Bipolar disorder - none
Psychotic spectrum disorder - none
ADHD - none
Completed suicide - paternal great-grandfather
Attempted suicide - none
Substance use disorders- paternal grandmother with alcohol and prescription drug use disorders

Medical History

G1P0A0
25 weeks pregnant-pregnant-pregnancy unplanned but wanted
No h/o seizures or head trauma
Menarche at age 16, periods have always been irregular
She plans to nurse

Current Medications

Fluoxetine 20 mg by mouth daily in the am
Prenatal Vitamins

Social History

Patient was born and raised in Northern Kentucky. She was raised by both parents in an intact family. Her mother worked as a nurse, and her father was a teacher. Both parents are living and together. She is an only child. Her childhood was difficult as her mother struggled with mental illness and was physically and emotionally abusive towards her. Also, there was much parental conflict at home. Her relationship with her mother has improved over the years. Given the benefit of her own education and psychotherapy, she can now recognize mother's moods as symptoms of mental illness and no longer feels that she caused them and is able to not take it personally.

She pursued a Psychology degree after finishing undergrad but had to take an extended break in the 1st year due to worsening of eating disorder and depression. She returned after a year-long break but relapsed again on restricting and purging and is currently on another medical leave from the program. She was improving and then learned of her pregnancy which has caused another setback. She hopes to eventually return to her studies and finish her degree. She wants to help women with eating disorders as a therapist.

She has been married for a year. Her husband is a car mechanic and she feels her marriage is supportive. She denies any intimate partner violence.

She denies any legal history.

Vital Signs
BP-92/50, heart rate-64, O2Sat-96, % Weight-105 pounds, Height-5ft1in, BMI-19.8

Mental Status Exam

General Appearance**:** Appears staged age, dress and grooming appropriate, good eye contact
Musculoskeletal**:** Muscle strength and tone-normal. Gait and station-normal
Motor Behavior**:** No psychomotor abnormalities
Cognition**:** Short-term and long-term memory intact, recall intact, executive function intact, alert, well oriented to person/ place and time, no deficits evident
Attitude**:** Cooperative
Speech**:** normal rate, rhythm, and clarity, normal articulation and spontaneity
Mood**:** Depressed, anxious
Affect**:** Restricted range; mood-congruent
Thought Processes: well organized, goal-directed, normal computation
Associations**:** Normal
Perceptions**:** No hallucinations or other abnormalities
Thought Content**:** No delusions, no obsessions, no violent thoughts
Insight / Judgement: Superficial insight, poor judgment
Suicidal Ideation**:** None
Homicidal Ideation**:** None
Orientation: Alert, oriented to self, place, time and situation
Recent and Remote Memory**:** Intact
Attention and Concentration**:** Intact
Fund of Knowledge**:** Average

Scales
EPDS-26/30- suggests severe depression
PHQ-9-20/27-suggests severe depression
GAD-7-18/21-suggests severe anxiety
MDQ- 0/13-not concerning for Bipolar spectrum illness

Lab Work
Remarkable for anemia with hemoglobin of 10.0 g/dl , low B12 at 190 pg/ml and low iron at 40 ug/dl

Diagnoses
- Anorexia nervosa -binge purging type, in partial remission, mild
- Major depression, recurrent, severe without psychosis
- Persistent depressive disorder, early onset, with intermittent major depressive episodes, with current episode, severe
- Post- traumatic stress Disorder

References

Soyama H, Miyamoto M, Natsuyama T, Takano M, Sasa H ,Furuya K...A case of refeeding syndrome in pregnancy with anorexia nervosa.Obstet Med. 2018 Jun;11(2):95-97

Santos AMD, Benute GRG, Santos NOD, Nomura RMY, de Lucia MCS, Francisco RPV4. Presence of eating disorders and its relationship to anxiety and depression in pregnant women. Midwifery. 2017 Aug;51:12-15.

Charbonneau KD MScFN (c), Seabrook JA PhD. Adverse Birth Outcomes Associated with Types of Eating Disorders: A Review. Can J Diet Pract Res. 2019 Feb 7:1-6.

Case Presentation Part 2: Pregnancy

She presents to the ER, brought in at the request of family. At 25 weeks pregnant, she weighs 105 lbs (BMI of 19.8) and pregnancy is barely visible. She is becoming increasingly obsessed with how her body looks. She feels that her arms look like “bat wings” and is disgusted that her thighs now touch each other when she sits. She constantly checks her appearance in the mirror to the point that she wakes up at night and checks herself in the mirror. She is spending much time every day changing outfits and making sure she does not" look fat” in whatever she wears.

Vital signs notable for BP 100/62, pulse 60. Laboratories notable for Phos of 1.5, Magnesium of 2.0.

Discussion Question (Treatment Challenges)

1) What maternal and fetal risks would you consider and affect your treatment recommendations?

Maternal Risks:	Fetal Risks:
• • •	• • • • • •

2) Considering these risks, what options for level of care would you recommend?

	Inpatient Psychiatric Hospitalization	Intensive outpatient program/Partial Hospitalization	Outpatient
Risks	• •	• •	• •

Bene-fits	• • •	•	•

3) Considering the risks/benefits of the options for level of care, you recommend inpatient psychiatric hospitalization. Lauren declines, stating she prefers outpatient level of care. She states that she knows that she has an eating disorder and feels that she can gain an adequate amount of weight through outpatient management. You explain the risk of refeeding syndrome, and she expresses understanding though continues to wish to be discharged as she reports a need to maintain her studies. *What further evaluation would be needed to determine level of care?*

References

Am J Obstet Gynecol. 2014 Oct;211(4):392.e1-8. doi: 10.1016/j.ajog.2014.03.067. Epub 2014 Apr 3.Pregnancy, obstetric, and perinatal health outcomes in eating disorders.

Crow SJ, Agras WS, Crosby R, Halmi K, Mitchell JE. Eating disorder symptoms in pregnancy: a prospective study. Int J Eat Disord. 2008 Apr;41(3):277-9.

Fogarty S, Elmir R, Hay P, Schmied V. The experience of women with an eating disorder in the perinatal period: a meta-ethnographic study. *BMC Pregnancy Childbirth*. 2018;18(1):121. Published 2018 May 2. doi:10.1186/s12884-018-1762-9

Linna MS1, Raevuori A2, Haukka J3, Suvisaari JM4, Suokas JT5, Gissler M6. S. Koubaa, T. Hällström, L. Hagenäs, A.L. Hirschberg. Retarded head growth and neurocognitive development in infants of mothers with a history of eating disorders: longitudinal cohort study. BJOG, 120 (2013), pp. 1413-1422

Case Presentation Part 3: Postpartum

After a successful six-week inpatient hospitalization during pregnancy, Lauren delivers a healthy baby girl vaginally at 38-weeks gestation. She has continued taking fluoxetine 20 mg daily and reports her mood is “good” and eating “is not an issue” at the time of delivery. She decides to breastfeed and is discharged to home with her daughter three days after giving birth.

Discussion Questions (Postpartum Challenges)

1) What concerns would you have for someone in the postpartum period with an eating disorder history?

2) Considering all biopsychosocial factors, what postpartum treatments would you consider for Lauren?

Case Presentation Part 3 *continued*

Six weeks later Lauren returns for her postpartum follow-up appointment. She reports feeling more overwhelmed and obsessive about food and weight gain since weight has not come off as easily as she hoped in the postpartum period. She states "everything feels out of my control" and "the only thing I can control is what I eat".

She describes her baby as "fussy and difficult". She notes her baby at times doesn't really seem interested in feeding and she wonders if her baby is gaining the appropriate amount of weight. She is also having trouble breastfeeding, but would like to continue because she has "heard it can help with weight loss." She states she is having a hard time meeting her high expectations for what a good mom would do and think; as a result, she is feeling like a failure.

She reports having low energy and feeling dizziness at times and states she knows she should be eating more, but is having difficulty forcing herself. She is already back to her pre-pregnancy weight and would like to start working out again. She reports negative thoughts about her body and "fears it will never be normal again." She remarks the cognitive therapy she did while inpatient was helpful and states that she would be willing to do that again. She is adamant about avoiding hospitalization for fear of being separated from her baby.

<u>Scales</u>
Edinburgh Postnatal Depression Scale: 20; Patient Health Questionnaire-9: 17; Generalized Anxiety Disorder-7: 18; Mood Disorder Questionnaire: 0

Discussion Questions

1) What additional information would you like at this point to make an effective treatment decision?

2) What maternal and risks to the infant would you consider and how would they affect your treatment recommendations?

Maternal Risks:	Risks for Infant:
• •	• • • •

3) Considering these risks, what options for level of care would you recommend?

	Inpatient Psychiatric Hospitalization	Intensive outpatient program/Partial Hospitalization	Outpatient
Risks	• •	• •	• •
Benefits	• • •	• •	• • •

Case Presentation Part 3 *continued*

After a collaborative discussion with Lauren and careful consideration of the risks and benefits to the mother and infant as well as the various treatment options, you decide to increase Fluoxetine to 30 mg daily and refer to a specialist who can start weekly individual Cognitive Behavioral or Interpersonal Psychotherapy given that both therapies have been found to be effective for depression and eating disorders in the postpartum period.

Discussion Question

1) What additional steps might you take to address Lauren's needs in the postpartum period?

References

Larrson G, Andersson-Ellstron A. Experiences of pregnancy-related body shape changes and of breast-feeding in women with a history of eating disorders. Eur Eat Disord Rev 2003;11:116-124.

Mazzeo SE, Slof-Op't Landt MC, Jones I, Mitchell K, Kendler KS, Neale MC, et al. Associations among postpartum depression, eating disorders, and perfectionism in a population-based sample of adult women. Int J Eat Disord 2006;39:202-11.

Micali N, De Stavola B, dos-Santos-Silva I, Steenweg-de Graaff J, Jansen P, Jaddoe V, Hofman A, Verhulst F, Steegers E, Tiemeier H. Perinatal outcomes and gestational weight gain in women with eating disorders: a population-based cohort study. BJOG 2012.

Micali N, Simonoff E, Treasure J. Risk of major adverse perinatal outcomes in women with eating disorders. Br J Psychiatry 2007;190:255-9.

Morgan JF, Lacey JH, Chung E. Risk of postnatal depression, miscarriage and preterm birth in bulimia nervosa: retrospective controlled study. Psychosom Med 2006;68:487-92.

Stein A, Woolley H, Cooper SD, Fairburn CG. An observational study of mothers with eating disorders and their infants. J Child Psychol Psychiatry 1994;35:733-48.

Kass AE, Kolko RP, Wilfley DE. Psychological treatments for eating disorders. Current Opinions in Psychiatry. 2013;26(6):549-55.