Eating Disorders & Postpartum Mental Health:

Staying Connected to Self and Recovery

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The Renfrew Center

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Objectives

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

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

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

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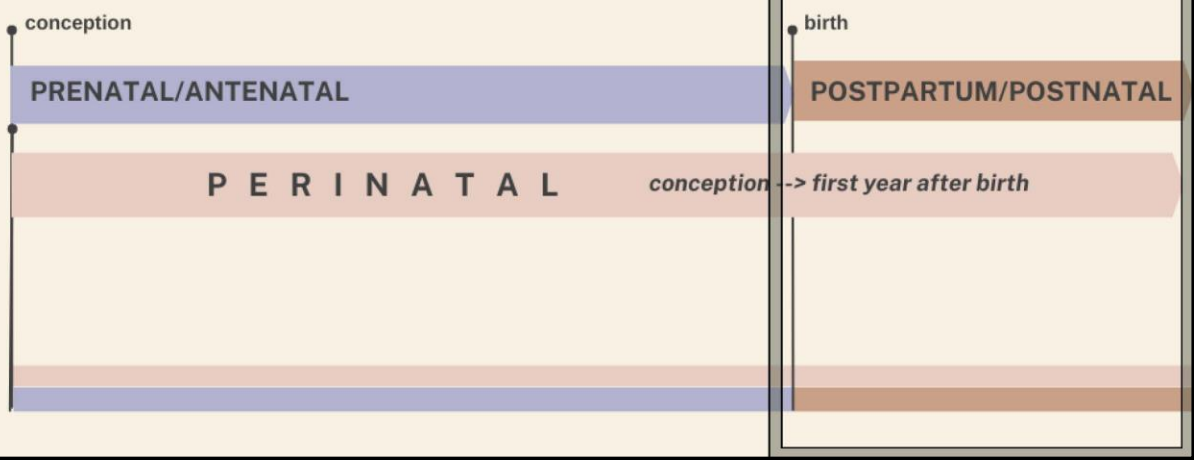
TERMINOLOGY



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Pregnancy vs Postpartum

Pregnancy

- 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)*
- Established care, seen bi-weekly, and then weekly after 35 weeks
  - High rate of ED remission in pregnancy (60-70%)
  - Up to 2/3 of people with an eating disorder and pregnant do not disclose to their doctor
- Weighed at every appointment*
- "Pregorexia"
- Conflicted feelings due to possible infertility struggles
- Water retention
- Hunger/fullness cues
- Hormones
- Morning sickness
- Exhaustion, breathlessness, acid reflux
- Body changes/may not "look" pregnant or may look "too pregnant" ("are there twins in there?")

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"I had a challenging pregnancy. I was extremely nauseous I would throw up at least 4-5 times a day and it lasted the entire pregnancy. The first trimester was the hardest as it typically is. All the throwing up did remind me of when I was bulimic, that sense of relief after it was done except this was from nausea. When I was bulimic I would be so anxious and the purge was the relief. It was almost relaxing that the anxiety of the food I ate could feel like I erased it. I wanted to have a baby, I knew I would struggle with my body image. No one talks about the REAL struggle of juggling it all"

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Different Struggles

Postpartum

- Matrescence: **the physical, emotional, hormonal and social transition to becoming a mother**
- We have those who went into remission during their pregnancy and are having struggles with the transition
- Those with active eating disorders who didn't reduce their behaviors
- Hormones drop, mood shifts
- More likely to have a hard time with the already hard transition.
  - Parent of multiples, NICU admissions, labor & delivery complications
- 1-2 appointments post-partum (2 weeks and 6 weeks)
- Scar healing/vaginal healing
- Body changes
- No Follow-up on care for ED, as their symptoms were missed
- Milk production
- Sleep deprivation
- Menses returns
- Change in appetite

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Postpartum Pressures

Media pressures "get your pre baby body back"	Be intimate with partner when not ready	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	That you should love being a mom/parent	Internal Pressure of competing identities • Eating Disorder Identity vs New Parent Identity

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- Discomfort with postpartum body
  - Likely the same body pre-pregnancy will never be the same post-partum
  - Affective & Attitudinal body-size estimates were significantly greater in people with eating disorders
- Birth Trauma - health complications
- Hunger/fullness cues off
  - Breastfeeding/caloric intake needed
- Postpartum discomfort from delivery
  - Nightsweats
  - Excess Fluid
  - C-section
- Return of menses
- Hairloss
- Still looking pregnant after birth
- Wanting to re-engage in exercise

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Postpartum issues we don't talk about

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

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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

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The Facts: Underdiagnosed & Under-screened

- Universal screening does not exist for either population.
  - Eating Disorders place people at an increased risk for PMAD
  - PMAD impacts 22% of the population
- Eating disorders affect ~28.8M 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

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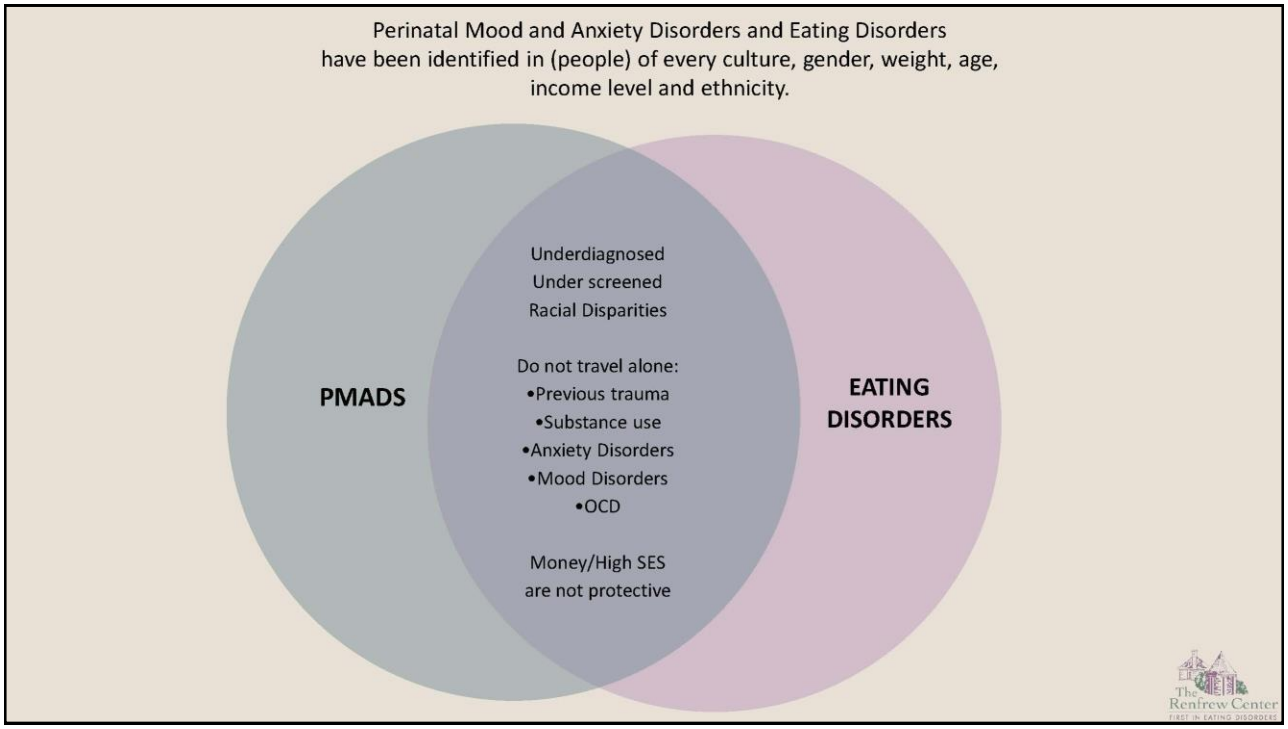
Perinatal Mood and Anxiety Disorders and Eating Disorders
have been identified in (people) of every culture, gender, weight, age,
income level and ethnicity.
PMADS
Underdiagnosed
Under screened
Racial Disparities
Do not travel alone:
•Previous trauma
•Substance use
•Anxiety Disorders
•Mood Disorders
•OCD
Money/High SES
are not protective
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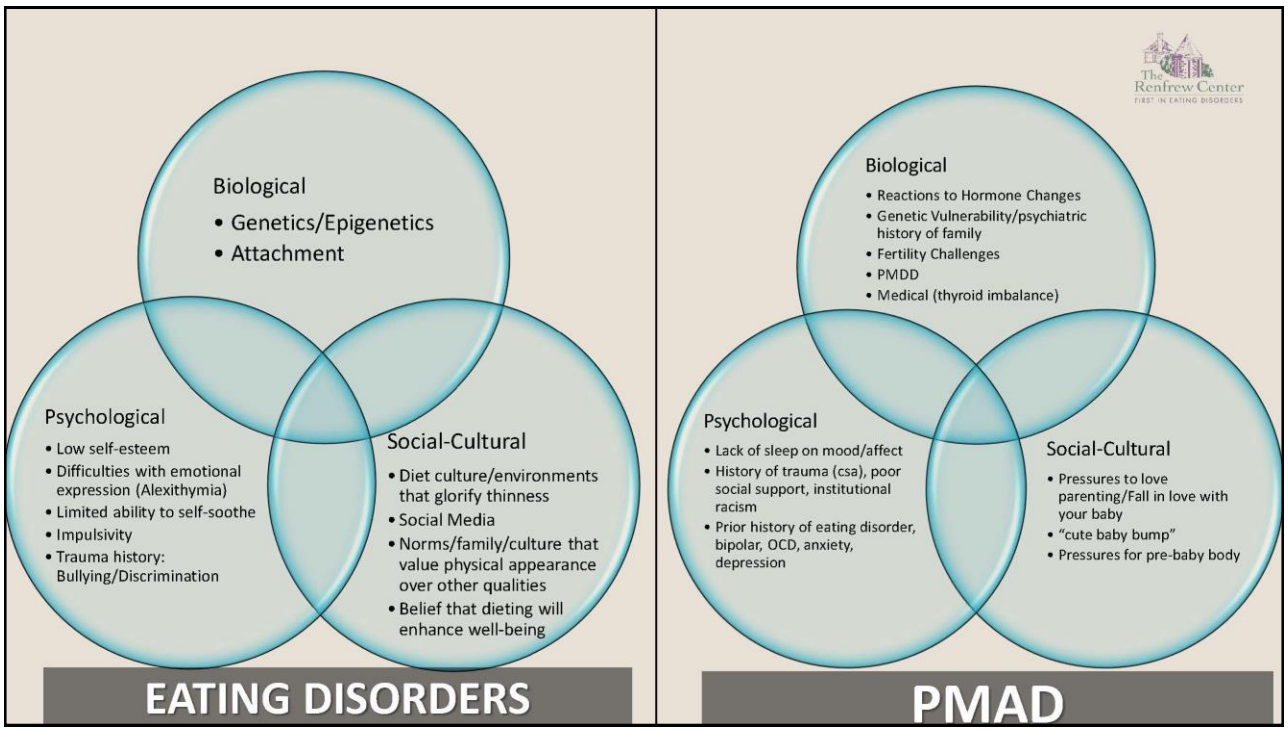
Biological
• Genetics/Epigenetics
• Attachment
Psychological
• Low self-esteem
• Difficulties with emotional expression (Alexithymia)
• Limited ability to self-soothe
• Impulsivity
• Trauma history: Bullying/Discrimination
Social-Cultural
• Diet culture/environments that glorify thinness
• Social Media
• Norms/family/culture that value physical appearance over other qualities
• Belief that dieting will enhance well-being
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Biological
• Reactions to Hormone Changes
• Genetic Vulnerability/psychiatric history of family
• Fertility Challenges
• PMDD
• Medical (thyroid imbalance)
Psychological
• Lack of sleep on mood/affect
• History of trauma (csa), poor social support, institutional racism
• Prior history of eating disorder, bipolar, OCD, anxiety, depression
Social-Cultural
• Pressures to love parenting/Fall in love with your baby
• "cute baby bump"
• Pressures for pre-baby body
PMAD

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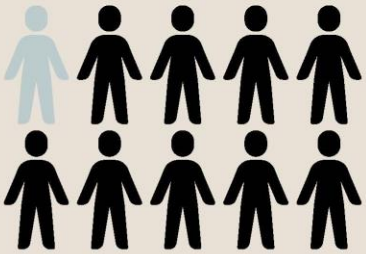
Perinatal Mood and Anxiety Disorders

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

1 in 5-7 moms suffer from Postpartum depression.



1 in 10 dads suffer from Postpartum Depression

(Paulson & Bazemore, JAMA 2010)

Priorities:

Early Identification

Postpartum Support Planning

Frequent Screening

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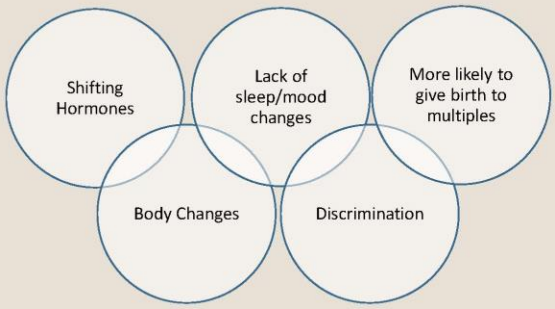
Not just impacting Cisgender Heterosexual Women

- 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).



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Not everything is "normal"

- Not all pregnancies are wanted, pts with Eds get pregnant unintentionally at 2x the rate of those who do not have EDs.
- PMADs can appear during pregnancy and up to a year after birth. **Common peak of risk is prevalent 3 months after birth**
- Diagnostic Fluctuation: Eating Disorder behaviors might look the same or present differently than pre-conception/pre-birth.
- If symptoms such as tearfulness, lability, reactivity, anger and severe exhaustion/disconnection persist after 2 weeks postpartum this is NOT the baby blues
- **Both EDs and PMADS do not usually resolve without treatment (Woolhouse H. et al. BJOG 2014).**

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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); (Daigle, K 2020, p. 127)

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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, 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, premature delivery, low birth weight babies and other risks due to malnourishment

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

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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

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PPD

- Feelings of Overwhelm
- If the birthing person experienced depression or anxiety previous in their life (as is very common with eating disorders) the likelihood of them developing PPD or PPA increases.
- Keep an eye out for thoughts that are personalized (i.e. I'm a bad mother, my baby doesn't deserve me, etc)

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Exacerbating Psychosocial Risk Factors of PMADs/EDs

- Inadequate partner/social support
- Interpersonal violence
- Other relationship stress
- Financial Stressors/Poverty
- Childcare Stressors
- Child illness
- Recent Loss or move
- Fertility issues
- Barriers to care
- Institutional racism
- Difficulty with transition

- Climates stressors: Seasonal Depression or Mania, past trauma/trauma anniversaries
- Complications in pregnancy, birth, or breastfeeding
- Temperament of baby
- Returning to work
- Unresolved Grief or loss
  - miscarriage, neonatal loss (stillbirth), elective abortion
  - Estrangement, complicated relationship or death of one's own mother
  - Missing "old" body, missing ED behaviors

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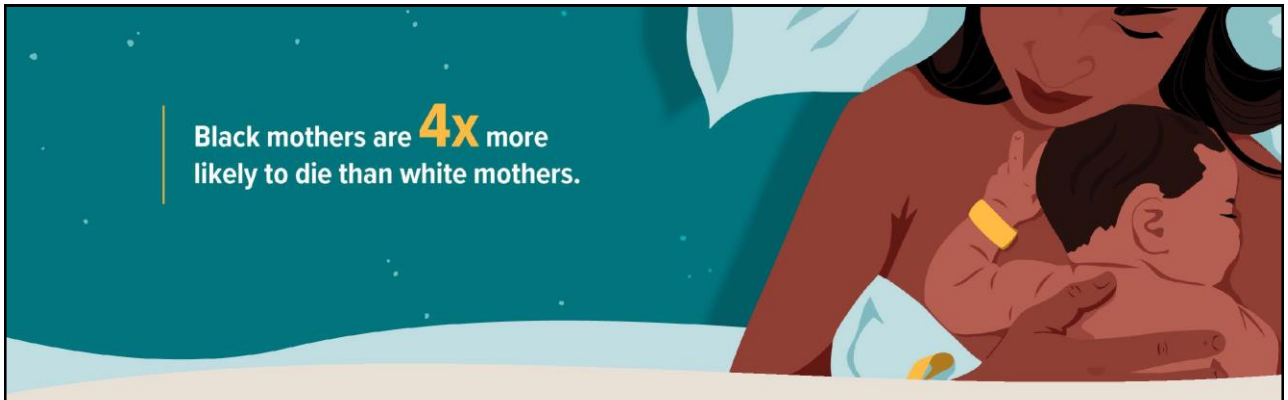

Communities of Color – Health Disparities

- 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**
- 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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Emotional Disorders

Core Vulnerabilities

- Temperamental propensity to experience negative affect more intensely and frequently;
- Tendency to view emotional experiences as unwanted and intolerable
- Unsustainable emotion regulation behavioral strategies (attempts to avoid or dampen the intensity of uncomfortable emotion)
- Common Emotional Disorders: EDs, Anxiety Disorders, OCD, PTSD

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Perinatal Anxiety

- "I became overwhelmed with ensuring she was eating enough, pooping enough, everything enough!"
- Helplessness may trigger ED thoughts and behavior
- "The bottles can not be washed by anyone but me" to "did I wash them thoroughly enough?"
- "Am I going to give them an eating disorder? What about good attachment?"
- Feeding worries
  - "solid food is so scary and I still stare at her the entire time she is eating in front of me. I'm absolutely terrified of her choking. As much as I don't want to admit it, I think there's a part of me that is fearful of not feeding her the right amount of food. When she was solely on formula this fear was less because it was pretty easy to just give her x number of ounces."

The Goal: Tease out what thoughts are related to postpartum anxiety and what is truly about a value (keeping baby safe while eating).

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Perinatal OCD

- OCD can onset for the very first time in this period, or different types of symptoms may creep up in this period if previously diagnosed
- EGO-DYSTONIC**
- Unwanted thoughts - **Intrusive thoughts do not mean that the person is more likely to act on them**
- Often misdiagnosed as psychosis and perinatal anxiety
- Does not just impact birthing parent (parents who adopted can show perinatal OCD as well)
- Focus on baby
  - "What if I stab/drown/drop my baby"
  - "what if I throw my baby down the laundry shoot"
  - Checks on baby's breathing, doesn't pick up baby for fear of dropping them, stops meal prep
  - *" I was very nervous that I would hurt the baby or that I was incapable of taking care of the baby. It's became part of the familiar "I can't" narrative that I struggled for years within my eating disorder"*

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Post-Traumatic Stress Disorder

The Three E's of Trauma:

Event(s), Experience, and Effect.

When a person is exposed to a traumatic or stressful event, how they experience it greatly influences the long-lasting adverse effects of carrying the weight of trauma.

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PTSD & Eating Disorders

- At least 52% of those with an eating disorder diagnosis have a history of trauma
- Eating disorders are often developed as unsustainable coping skills, stemming from survival
- Risk factors for eating disorder development are often PTSD symptoms such as having difficulty regulating emotions, negative self-view, feelings of shame, and negative emotion-states.
- Food becomes a way to develop safety

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PTSD & PMAD

Postpartum Posttraumatic Stress Disorder: **An estimated 9% of people experience PTSD following childbirth (Beck C, et al Birth 2011).**

Symptoms typically include:

- Traumatic childbirth experience with a reexperiencing of the trauma (dreams, thoughts, etc.)
- Avoidance of stimuli associated with the event (thoughts, feelings, people, places, details of event, etc.),
- Persistent increased arousal (irritability, difficulty sleeping, hypervigilance, exaggerated startle response).

Most often, this is caused by a real or perceived trauma during delivery or postpartum. These traumas could include:

- Prolapsed cord
- Unplanned/emergency C-section
- Use of vacuum extractor or forceps to deliver the baby
- Baby going to NICU
- Feelings of powerlessness, poor communication and/or lack of support and reassurance during the delivery
- People who have experienced a previous trauma, such as rape or sexual abuse, are also at a higher risk for experiencing postpartum PTSD.
- People who have experienced a severe physical complication or injury related to pregnancy or childbirth, such as severe postpartum hemorrhage, unexpected hysterectomy, severe preeclampsia/eclampsia, perineal trauma (3rd or 4th degree tear), or cardiac disease.

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PTSD & EDs

A great deal of research has been conducted on the relationship between PTSD and eating disorders and the following has been learned by researchers:

- Approximately 26% of those with BED have co-occurring PTSD (NEDA)
- Approximately 13.7% of those with anorexia nervosa meet criteria for PTSD
- Approximately 37 to 40% of those with bulimia nervosa experience co-occurring PTSD

Rates of PTSD are higher in individuals with purging behaviors than any other eating disorder behaviors

- Some researchers theorize that the neurological response to purging leads to feelings of euphoria which allows disconnection from trauma memories/responses, explaining this dynamic.

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Goals and interventions: Taking care of the caregiver

When a caregiver responds consistently to a baby's needs, baby become resilient, and a child becomes able to regulate themself as they become older.

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Evidenced Based Treatments for PMAD and ED

Exposure and Response Prevention
AN/restrictive patterns, POCD

Unified Protocol
Transdiagnostic CBT

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

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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 enable 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.

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Common Goals

- To increase connection (eating disorders are disorders of disconnection) interpersonally and intrapersonally
- To become their own emotional expert
- Identity and Values Identification
- Reducing perfectionism and comparison
- Communication and Conflict Resolution – How do they disconnect?
- Anger Management and working through being touched out
- Grief and Loss Resolution
- Supports and Referral for Connection
- ***ALL goals to be with the intention of reducing anti-fatness/anti-fat bias***

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Perinatal Psychiatrist

Support people and groups

Therapist

Care Team

Doula*

Registered Dietitian

OB/GYN or Midwife

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

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

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"I felt unattractive and anxious about [my body] when friends around me were "all belly". I have really come to hate that term that is thrown around so often. Like growing a human is supposed to look a specific way. Like it's ok to get larger but just make sure it is in the most pleasing way for others.

I have almost zero pictures of myself pregnant. I still have a hard time thinking about it. My friend has a picture from my baby shower and said she'll show me it when I'm ready. Which makes me really sad. And it pains me to think about it, because it really is this amazing thing. Pregnancy was really hard for me looking back I might have been depressed. I didn't want to go anywhere and I was always afraid of someone seeing me."

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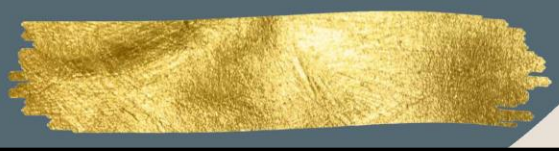
"[Shame for my body] postpartum started when the discharge nurse showed me my chart and how much I weighed. Something I had asked not to see throughout my whole pregnancy. It was a number that shocked me. I tried really hard not to let that get in the way of me bringing home my baby so I pushed it down. Post Partum body wise has had its ups and downs. Some days I feel powerful that my body was able to carry the person I love most in this world. Other days I get incredible anxiety and pain about how I don't recognize myself any more. How I went through recovery and then pregnancy all within a short time frame. I never got to know my non eating disordered body and this body feels very foreign to me. It's an ongoing battle and some days are better than others."



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Goal: To work on healthy attachment
Intervention: Bonding

Prenatal anxiety and depression have higher likelihood of emerging in the perinatal period if a person has an eating disorder, which can impact attachment with the child.

- Childhood wounds
- Past trauma
- Active eating disorders during pregnancy and postpartum can impact meal times, bonding with kids

Research has found no negative effects from an eating disorder on the parent-child relationship if the mother has been in sustained recovery.

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Goal: To reconnect with the body

40% of new mothers are dissatisfied with their weight and have poor body image after giving birth. Lemberg & Phillips (1989).

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Postpartum Pressures that influence body Image

- **Comments from family, friends and others about our, their, and other people's bodies**
- **Difficulty with life stressors**
- **Intimacy, pleasing partner**
- **Ideals about physical appearance, pressures to "bounce back"**
- **Exposure to images of idealized bodies**
- **Comparison**
- **Gender identity**
- **Past Trauma**

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Body Grief

- Coined By Brianna Campos, @BodyImageWithBri
- **Definition:** the distress caused by the perceived losses that come when you stop attempting to change your body size
- Body Image work to be centered on reducing anti-fat bias/anti-fatness or "the attitudes, behaviors, and social systems that specifically marginalize, exclude, underserve, and oppress fat bodies."
  - "When did you learn that bodies needed fixing?" "when did you learn there are good bodies and bad bodies?" "Who told you that your body was wrong? Are they reliable sources?"
- *"I am experiencing a lot of body grief since bringing home the baby. I think because I am unable to access my eating disorder behaviors as easily as I once was, there's grief in knowing that I might live with this body for a longer period of time than my eating disorder wants me to. At the same time, I think part of me cares less about what my body thinks of me and sees it as a source of comfort for my baby even if it can't bring me comfort."*
- Body Grief & Intimacy:
- *"Being intimate has been a challenge for me. As it was something I always worried about. A belly that now shakes makes me cringe sometimes. My partner is exactly the same treats me the same way as if my body never changed. It's all internal and I know that."*

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Goals for supporting ED postpartum

- The ability to recognize signs of relapse and to seek appropriate help if relapse occurs.
- Ask about their body story and motivation for changing the environment for themselves and their baby. Reparenting themselves in the process
- Triggers for relapse thinking or behaviors can be identified.
- Ask about medical support and advocacy
- Awareness of cognitive distortions and temperament risks (Perfectionism, Emotional reasoning, Personalizing).

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- CONNECTION
  - To increase support prior to birth for postpartum
  - Education on emotional tolerance
- Take a full assessment for depression, anxiety, OCD, eating disorder behaviors
- "Postpartum Care Plan" (Kleiman, 2005)

Interventions

- Postpartum Doulas
  - "I Had a traumatic birth, I had pre-enclampsia and HBP, and was in labor for 3 days. It was traumatic. However, I felt in charge of every decision I made. That made me feel supported a huge part of my doula being with me"
- Group Therapy/Resources
- Increase partner involvement (if applicable) or another person in recovery
- Meal train
- Increase of sessions
- Mindfulness

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Mindfulness is being FULLY AWARE

Allows you to pause, think and decide how to respond

Aware of primary and secondary emotions

Present-focused awareness of emotions: physical sensations, thoughts, behaviors/urges

Non-Judgmental acceptance of emotions

Capacity to NOT act on less than helpful urges

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"Honestly just doing things that scare me is what helps me the most. It's something that I continue to try to tell myself, the repetitiveness [of not acting on my thoughts] is what makes it start to feel safer. Also realizing that [my extremely negative thoughts about myself] usually starts with a worry about something else, but my body was always the outlet either through hating it or through restriction and bingeing. I stop and try to think 'ok what am I really worried about right now?'"

Finding out that I may have Perinatal OCD has been very helpful and makes sense given my history. I was never diagnosed until I sought out treatment postpartum. I feel like at 33 I'm finally starting to understand my brain more and why I get so fixated on very specific things. It helps me cope when I can see it from another angle."

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Supporting new parents in their recovery

- Early Intervention – screen often, look for behavioral cues
- 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)
- Dig deeper into body image
- Therapeutic Connection and attachment
  - As relational connection increases, eating disorder symptomology decreases
- Postpartum Support Plan

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Postpartum Support Plan

- Help to manage the "to-do" list
- **Feeding:** Meal planning for baby and parents – ask how they plan to feed baby, and contingency plans
- Identifying what others can do
- **Visitors**
- **Roles**
- Relationship with partner (if available)
- **Addressing sleep hygiene**
- Access to doula services
- Don't forget the partner!
  - What is their relationship to food?
  - Do they have access to care?
    - *"My baby is 10 months old and I still experience waves of the intrusive thoughts. I recall the first time I really noticed that they were affecting my life was around 5 or 6 months. I felt ashamed and confused by the level of anxiety I felt and it seemed very random for it to occur at the 5-6 month mark...like, shouldn't things be starting to feel easier?"*

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Assessment for Eating Disorders & Perinatal Mood & Anxiety Disorders

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Screening Recommendations – No Consensus

American College of Obstetricians and Gynecologists (ACOG) recommends screening 1x during the perinatal period

American Academy of Pediatrics recommend screening at 1, 2, 4, and 6 month visit

Annals of Family Medicine: repeated PPD screening at 6 and 12 months

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Postpartum Support International Recommends..

- First Prenatal Visit
- At least once in the second trimester
- At least once in the third trimester
- Six-week postpartum obstetrical visit (or at first postpartum visit)
- Repeated screening at 6 and/or 12 months in OB and primary care settings
- 3, 9, and 12-month pediatric visits

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"With [my first child] in 2018 I was given a handout at my 6-week postpartum visit with questions to answer based upon a scale, I think the that's the typical depression screening. No eating disorder screening. I answered them but I remember feeling like if I answered too intensely in one direction I would have my baby taken away. No joke. No one explained anything to me. The nurse looked over it and gave me my exam and said ok you're good. Told me I should get on birth control because I WILL get pregnant otherwise. It was terrifying. Looking back, I really needed support. "

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Who needs to be screened for PMAD?

- ALL with eating disorders and trauma
  - All people who may have a relationship with food (yes, that means everyone!)
  - If prior miscarriage, birth trauma, stillbirth
- Birthing parent
- Partner
  - Depression tends to spike 3-6 months postpartum for partners
  - 1 in 10 new fathers* meet criteria for depression postpartum
- Adoptive parents

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Screening for eating disorders

- Thinking pattern, preoccupation of body concerns
- 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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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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Red Flags

Only feeding baby, forgetting to eat	Binges increase	Consumed with thoughts related to body size, losing weight, unhealthy obsession with exercising	Frequent "body checking" in mirror	Am I going to still be loveable In this body?
Comparing self to other parents	Trying on "pre-baby" clothes	Breastfeeding complications	Hiding body with clothes (ex: wearing baggy clothes, changing multiple times)	Drinking excessive amounts of water, chewing gum, eating mints
	Food rituals- mixing foods, cutting food into small bites, eating very quickly	Avoiding eating in front of others/excuses for not eating	Becoming socially isolated, avoiding peers	

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Questions to Consider

Can you eat when you are hungry and quit when you are satisfied?	Can you walk me through mealtimes at home?	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? Including foods that are high in fat or calories?	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?

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Most effective treatment focuses on what is maintaining the Eating Disorder rather than what caused it

- Effects of Starvation or Altered Nutrition
- Healthcare avoidance assessment
- Advocacy on turning down being weighed (unless medically necessary)
- Unpacking Internalized weight bias/fatphobia/healthism
- Rigidity—Inflexible thinking/limited behavioral repertoire
- Temperament—harm avoidant, anxious, perfectionistic

- Reconnecting with self & others
- Identifying core values
- Relational response to ED behavior
- **Experiential Avoidance**
- **Emotional Avoidance**

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Avoidance as a maintaining factor

- **Emotions** themselves are **not unsafe**, dangerous or threatening
- **Attempts to avoid** uncomfortable and painful emotional experiences **drives unsafe**, threatening and dangerous **behavior** (symptom use).

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In a nutshell

- **Early Identification – ASK & look for warning signs**
  - people can recover faster and for longer
- **Early intervention is ESSENTIAL**
  - More readily identify those at risk and in need of further evaluation
  - Reduce overall prevalence of perinatal mood and anxiety disorders and increase rates of remission/treatment response
- **Postpartum Support Planning**
- **Practicing from an anti-diet, fat-positive, anti-fat bias lens is critical**

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Resources:

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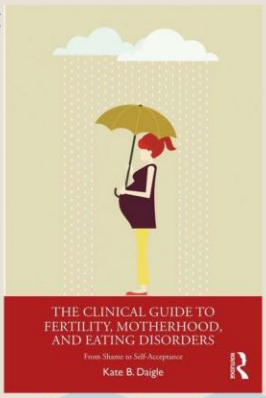
POSTPARTUM SUPPORT INTERNATIONAL PSI

- Postpartum Support International: **https://www.postpartum.net/**
- The Clinical Guide to Fertility, Motherhood, and Eating Disorders – Kate B. Daigle LPC
- Good Moms have Scary Thoughts – Karen Kleiman & Molly McIntyre
- ANAD
- The Renfrew Center
- 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*



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Thank you!

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Questions?

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