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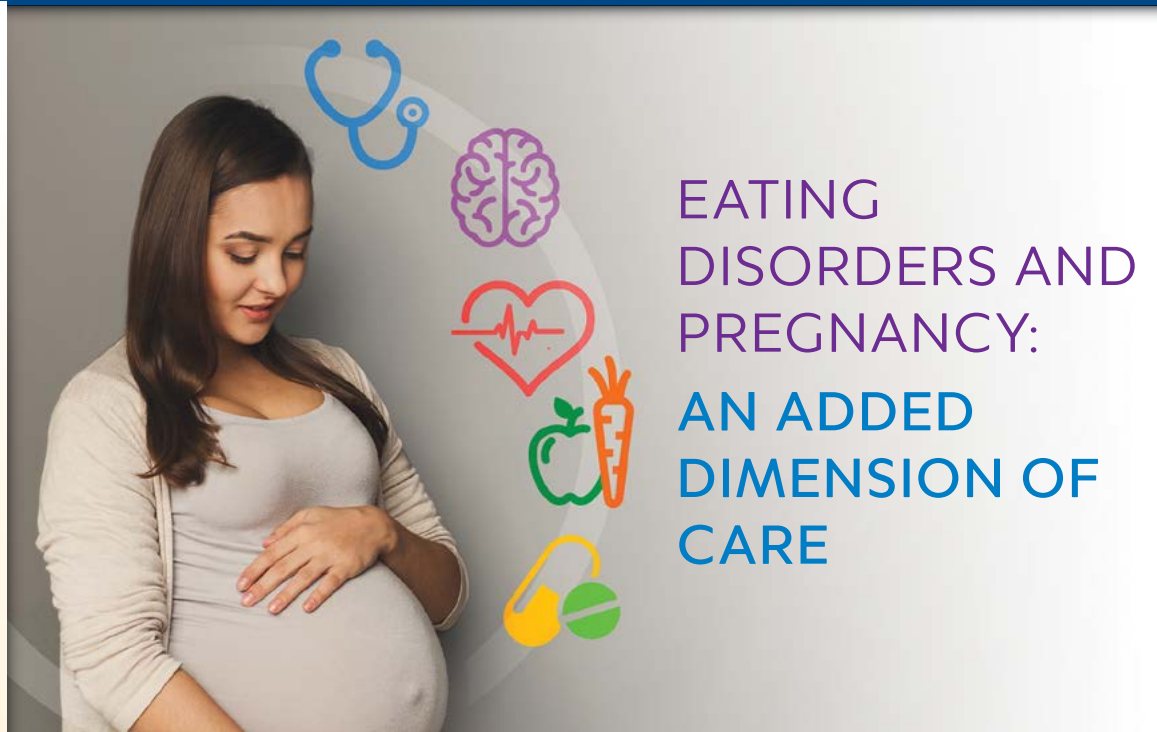
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EATING DISORDERS AND PREGNANCY: AN ADDED DIMENSION OF CARE

When a patient with an eating disorder is pregnant, two lives are at risk.

"Comprehensive treatment must incorporate the medical and psychiatric elements of an eating disorder and extend to the joys, hopes, and anxieties related to the developing life, while also addressing the physical health of both mother and baby," says Lynnette Peoples, MSN, PMHCNS-BC, APN, Director of Princeton Center for Eating Disorders. "In this special circumstance, the care plan should be both interdisciplinary and interdepartmental, which is a distinct advantage of our hospital-based setting."

Medical Concerns

In addition to health problems for the patient, each type of eating disorder can present different risks for a developing baby, according to Jose Vazquez, MD, Medical Director of Psychiatric Services at Princeton Medical Center. In general, issues that can affect the fetus include electrolyte imbalances, mineral or folic acid depletion, low blood sugar, dehydration, and cardiac arrhythmias in the mother, as well as inadequate weight gain.

"The first three months of pregnancy are critical to a baby's development, so if a patient is struggling with an eating disorder, early treatment and education during pregnancy is very important," says Dr. Vazquez. "Counseling a patient about gaining weight can be challenging, but inadequate weight gain and maternal complications during pregnancy can lead to low birthweight, prematurity, and lifelong effects for the baby, including learning, neurological, and cardiac problems."

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With education a key component of care, pregnant patients tend to be more compliant and understanding of their role in creating a healthy baby once they are in a structured inpatient setting, according to Dr. Vazquez. Likewise, medical issues can be controlled via monitoring, testing, medications, and care from on-site specialists such as endocrinologists and cardiologists. Princeton Medical Center also offers an engaged, comprehensive service line for obstetrics/gynecology and maternal health.

Therapy Considerations

In some cases, a patient's desire for her baby to be healthy supersedes anxiety about her own body, and she may be willing to tolerate the physical changes of pregnancy in the interest of the baby. In other situations, pregnancy can worsen anxiety, fear, or the lack of perceived control, causing internal conflict and even resentment.

A focus of therapy is to address these factors within the whole constellation of issues a patient may be experiencing, according to Allison Lansky, EdS, LMFT, CEDS, NCC, Lead Senior Primary Therapist at Princeton Center for Eating Disorders.

"We work with patients to pinpoint fears, recognize motivations, and identify healthy forms of control," says Lansky. "It's important to understand that sometimes even asking for help can be empowering."

"We also help them look at the pregnancy from a logical standpoint, including the risk factors of not eating, as well as from a reflective perspective," she adds. "It can be therapeutic to explore questions like the parenting values they want to have and the kind of parent they hope to be."



OBSTETRIC ADVANTAGES OF A HOSPITAL-BASED SETTING



"Because we are in a hospital setting, we are able to coordinate all aspects of a pregnant patient's care, enabling them to get the services they need in the quickest, easiest way possible," says Jennifer Hollander, RN, MSN, Director of Patient Care Services at Princeton Center for Eating Disorders.

During treatment for an eating disorder, an obstetrician/gynecologist at Princeton Medical Center is fully involved in each pregnant patient's care. The on-site Maternal/Fetal Medicine Department conducts prenatal tests such as ultrasounds and fetal stress tests, and can provide diagnostic and treatment services for any special pregnancy-related needs. In addition, nurses from the Labor and Delivery Unit often meet with patients to provide education and support.

"From the obstetrics perspective, one of our biggest concerns is the growth of the baby," says Jeffrey Hofman, MD, Division Chief of Obstetrics at Princeton Health, who provides obstetrical care for pregnant patients receiving inpatient care. "Because low birthweight is a risk that can have a variety of implications for the baby, we work together to closely monitor pregnancy parameters. In some cases, this may mean additional ultrasounds and lab tests."

In addition to in-house collaboration, Dr. Hofman and the obstetrical team ensure ongoing communication with each patient's regular outpatient obstetrician, so care is seamless upon discharge. Providing insight to the baby's pediatrician, if one has been identified, is also a critical part of care continuity.



When Healthy Eating Crosses the Line

From plant-based eating to paleo, the latest health food trends and diets are popular topics in today's media—and as a result, a more conscious focus on what we consume is becoming increasingly common. In some cases, however, this emphasis can shift into an obsession in the form of orthorexia nervosa.

While not formally recognized under DSM-5, orthorexia is an excessive preoccupation with healthy eating that escalates into rigid, self-imposed food restrictions with negative health consequences.

"Orthorexia is a form of dietary perfectionism that can take over nearly every aspect of life," says Najeeb Riaz, MD, Medical Director of Princeton Center for Eating Disorders. "It may start by eliminating categories like dairy, meat, or gluten, but eventually the list of acceptable food options becomes dangerously narrow."

Those with perfectionist tendencies or obsessive-compulsive disorder (OCD) may be at increased risk for developing orthorexia, according to Dr. Riaz. Many become intensely preoccupied with determining the origins of what they consume, which can lead to social impairments.


"It becomes nearly impossible for those with orthorexia to go to a restaurant or social gathering when they don't know the sources of food ingredients," explains Dr. Riaz. "They also may have a condescending attitude toward those who are not practicing the same rigid approach to eating."

The Physical Impact

The body needs a full range of food groups for various purposes, including maintaining strong muscles and bones, providing energy, and boosting the immune system, according to Dr. Riaz. When one area is not functioning appropriately, it can impact all other systems. As such, the limitations imposed by those with orthorexia can result in:

- Vital sign changes
- Dizziness and weakness
- Metabolic changes, such as low potassium levels, which can impact nerve and muscle cells, or low calcium levels that can lead to osteopenia or osteoporosis
- Orthostatic (postural) hypotension and low blood oxygen levels that can lead to cardiac complications like congestive heart failure
- Weight loss and malnutrition that can evolve into anorexia nervosa

Patients with orthorexia who are below 85 percent of their ideal body weight are candidates for inpatient treatment at Princeton Center for Eating Disorders. Comprehensive treatment includes individual and group psychoeducation and psychotherapy, daily medical monitoring, and psychopharmacology when needed to address issues like anxiety or obsessive-compulsive disorder.

 Education, support, and the establishment of a therapeutic relationship are vital in treating patients with orthorexia, and they provide a baseline for our care here," adds Dr. Riaz. "Their belief system about foods is very strong, so trust must first be established to enable work toward positive long-term outcomes."

Beyond Eating for Two:

Practical Nutrition Considerations During Pregnancy

For pregnant patients with eating disorders, ensuring proper nutrition during treatment takes on added significance.

“The need for weight gain during pregnancy can be very traumatic for women suffering from an eating disorder,” says Kristina Krill, MS, RD, Nutrition Therapist at Princeton Center for Eating Disorders. “Our role is to help them get the nutrition they need while explaining what each nutrient is doing for them and for the health of the baby.”

According to Krill, special nutrition considerations during pregnancy include:

Identifying the appropriate target weight. Typically, the Robinson formula is used to pinpoint normal target weight prior to pregnancy. For patients with a normal BMI, the recommended weight gain during pregnancy is 25 to 35 pounds. Underweight patients should have a weight gain of 28 to 40 pounds beyond goal weight. For example, if an underweight patient’s goal weight is 120 pounds, the pregnancy goal weight is 148 to 160 pounds.

Adding extra calories. During the second trimester, 340 extra calories per day are needed for the baby—the equivalent of an extra snack like peanut butter sandwich crackers or a nutrition shake. During the third trimester, 450 extra calories are needed per day. Framing this as an “extra requirement for baby” on the meal plan can make it seem less intimidating for patients.

“When educating patients, we avoid expressions like ‘eating for two,’” adds Krill. “This can seem scary, especially when a patient doesn’t want to eat for one.”



Ensuring fluid intake. Drinking plenty of fluids is especially important during pregnancy to prevent dehydration, which can lead to premature contractions. Starting with a base recommendation of about 2.4 liters of fluids per day, intake is adjusted based on a patient’s metabolic panel.

Getting the right nutrients. Meal plans incorporate certain key nutrients needed during pregnancy, such as:

- Folate to prevent neural tube defects
- Calcium, especially during the second and third trimesters when a baby’s bones and teeth are developing
- Iron to prevent anemia
- Zinc to help promote fetal growth
- Fiber to prevent constipation

Food safety. The kitchen at Princeton Medical Center adheres to rigorous food safety standards, and patients are educated about food precautions that should be taken during pregnancy. This includes avoiding raw fish and unpasteurized products.

“Patients also may have additional lab work to ensure that they are reaching target levels with various parameters,” says Krill. “Through these approaches—paired with biweekly dietitian meetings and three distinct nutrition groups—we make the nutritional health and safety of both mom and baby a key priority during treatment.”

Targeting the Root Cause of Food Aversions in Children

It's not uncommon for a child or teenager to exhibit picky eating behaviors. But when self-imposed food restrictions begin to affect growth and development, an evaluation for avoidant/restrictive food intake disorder (ARFID) may be needed.

In ARFID, individuals restrict or avoid foods to the point where they are unable to meet the nutritional requirements of the body. Unlike other common eating disorders, however, this occurs in the absence of body image issues or concerns. Common signs include placing increasing limits on foods, portion sizes, or the number of meals per day, as well as verbal aggression, irritability, or feeling overwhelmed during meals.

"ARFID is most often diagnosed in childhood or adolescence, and it is commonly linked to other comorbid conditions," explains Asad Hussain, MD, Associate Medical Director of Princeton Center for Eating Disorders. "The first step may be to rule out a medical reason with a gastroenterologist. From there, a thorough psychiatric evaluation is vital to shed light on the underlying cause, which leads us to the right course of treatment."

Conditions that frequently co-occur with ARFID include:

An anxiety disorder such as obsessive/compulsive disorder. This can precipitate ARFID, but it can also develop as a result of the fear of eating.

Past trauma related to eating, such as choking or excessive vomiting. Those with past trauma may even fear that they will die if they eat certain foods.

A sensory processing disorder that involves aversion to the smell, taste, or texture of foods. Occupational therapists at Princeton Medical Center can assess for this condition.



For growing children and teens, inadequate nutrition is a significant concern that can lead to longer-term effects, such as delayed milestones and failure to reach optimal height.

"We focus on weight restoration so that patients are medically stable, while providing psychotherapy and psychoeducation for both patients and their families," says Dr. Hussain. "Relapse prevention is a key part of treatment from day one, and we offer tools that can be carried forward in the home setting."

Medication also can be effective for some children and teens with ARFID. Depending on comorbid conditions, neuroleptics or anti-anxiety/antidepressant medications can be used to stimulate appetite and decrease anxiety and impulsivity without negative cognitive effects. When needed, medications are started at a low dose and titrated at a conservative pace to identify the optimal therapeutic dose.

"We strategize day-to-day across disciplines to identify and address patient needs as they evolve," adds Dr. Hussain. "This type of collaboration helps ensure greater success in treatment."

MEET THE TEAM



Dr. Hussain Joins the Eating Disorders Team

After two years of serving Princeton Medical Center in a telepsychiatry capacity, Asad Hussain, MD was appointed Associate Medical Director of Princeton Center for Eating Disorders in November 2018. A board-certified psychiatrist, his experience ranges from child and adolescent to geriatric psychiatry in hospital, residential center, and private practice settings.

"In this new role, I can focus on both the psychiatric and medical needs of patients," says Dr. Hussain. "Everyone here supports and inspires each other from the clinical and personal perspectives, which benefits the team as well as our patients."

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The Scent of Relaxation

When aromatherapy was introduced into many of the weekly relaxation group sessions at Princeton Center for Eating Disorders last year, the feedback was overwhelmingly positive.

“The goal of these sessions is to help patients relieve stress and promote the health of the mind, body, and spirit in an emotionally supportive environment,” says Jodi-Ann Forrest, BA, Mental Health Associate at Princeton Center for Eating Disorders. “Scents can be very powerful, and we’ve found that aromatherapy enhances the relaxation dynamic for many patients.”

Traditionally, the group begins with progressive muscle relaxation or a guided meditation with calming background music. For example, patients may be asked to close their eyes and picture themselves on a beach on a sunny day. While seated on the ground, they are guided through deep breathing exercises and slow, relaxing movements.

When adding aromatherapy, Forrest diffuses different combinations of essential oils, such as lavender and clary sage. Essential oils are typically extracted from plants for therapeutic purposes. Aromatherapy is thought to work by sending messages from receptors in the nose through the nervous system to the limbic system, which controls basic emotions.

Both aromatherapy and relaxation techniques are easy to implement at home.

“This practice has many benefits during treatment, but it’s also a healthy coping mechanism that patients can take with them to reduce anxiety and promote well-being,” says Forrest. “In some cases, it can even alleviate issues like headaches or promote better sleep.”

The therapeutic atmosphere generally results in a full group of eight to nine patients per session.

This group even helps me as the facilitator,” adds Forrest. “At the end of a hectic day, it helps us all feel more grounded and at ease.”

