Parenthood and eating disorders

A TAILORED IN-PATIENT TREATMENT PROGRAM

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PARENTHOOD AND EATING DISORDERS

Abstrakt

Flere studier viser at barn av mødre med psykiske lidelser har økt risiko for utviklingsforstyrrelser, kognitive vansker, fysiske symptomer og skader, samt atferdsmessige og følelsesmessige problemer. Et behandlingsprogram for gravide og foreldre med spiseforstyrrelser (SF) er utviklet ved Regionalt Kompetansesenter for Spiseforstyrrelser (RKSF) ved Levanger Sykehus. Formålet med denne rapporten er å beskrive dette «Foreldreprogrammet», samt beskrive helsepersonells erfaringer med denne intervensjonen ved RKSF. Dette behandlingsprogrammet er basert på elementer tatt fra 1) Tilknytningsteori, 2) Foreldreveiledningskurset «Trygghetssirkelen» (COS-P) 3) «Barnas Time», 4) kvalitative studier av foreldre med SF 5) kombinert med klinisk erfaring med SF og foreldreskap.

Erfaringer med dette programmet viser kompleksiteten ved å ha en spiseforstyrrelse kombinert med foreldrerollen.

Nøkkelord: Spiseforstyrrelser, familie og barn, døgnbehandling, utviklingspsykologi

Det er ingen kjente interessekonflikter.

INTRODUCTION

A large body of evidence have shown that children whose mothers suffer from mental disorder are at increased risk for developmental delays, cognitive and functional impairments, physical symptoms and injuries, as well as behavioural and emotional problems (Bagner, Pettit, Lewinsohn, & Seeley, 2010; Bleuler, 1974; Bureau, Easterbrooks, & Lyons-Ruth, 2009; Cornish et al., 2005; Field et al., 2008; Halligan, Murray, Martins, & Cooper, 2007; Lindgren, 2001).

Eating disorders (EDs) are common among women at childbearing age, and Anorexia Nervosa (AN) and Bulimia Nervosa (BN) affect about 8 percent of women during their reproductive age (Easter et al., 2013). It has also been shown that at least 1 in 20 women experience some form of ED during pregnancy (Bulik et al., 2007; Easter et al., 2013; Watson et al., 2013). At post-partum, 11.5 percent of women has reported some type of an ED (Larsson & Andersson-Ellström, 2003). ED may in some cases cause amenorrhea, irregular menstruation, and alteration of the normal hormonal balance, leading to fertility problems (Brinch, Isager, & Tolstrup, 1988; Crow, Thuras, Keel, & Mitchell, 2002; Easter, Treasure, & Micali, 2011; Micali et al., 2013), however individuals with ED do have children, hence there is a need for increased knowledge and treatment of parents with ED.

Some parents with ED experience elaborate negative feelings and some women with ED experience relapses in the post-partum period (Taborelli et al., 2016). A relapse in the post-partum period may lead to feelings of an experience of inadequacy as a mother, combined with shame, which again may underpin post-partum depressive feelings (Jones, 2007). More, women with AN have been found to be vulnerable to relapse periods postpartum, even if they have been symptom free for years (Franzen & Gerlinghoff, 1997). Of concern, as the mental health of parents has been shown to affect children's development.

An earlier qualitative study showed that mothers with ED reported numerous negative experiences with pregnancy and motherhood (Eik-Nes, 2011). For some, body image concerns are especially difficult in pregnancy and many women with ED describe a desire to lose weight after childbirth which can trigger ED symptoms (Brinch M, 1988).

Parenthood may be challenging for all parents in many ways, regardless of having an ED. Being pregnant and becoming a parent may be a vulnerable phase for some women, especially those suffering from mental health problems. Due to their mental health problems, some may sacrifice their own health for the sake of their children's well-being (Ruddick, 1989), which may affect their ability of being a parent (A. Stein, Wooley, & McPherson, 1999), and accordingly their children's development (A. Stein, 2002). Such a sacrifice may have harmful consequences for the children, as the children may internalize the parents' experiences (Barnett, Buckroyd, & Windle, 2005). Research shows that many mothers with ED experience parenting as challenging and difficult (Agras, Hammer, & McNicholas, 1999; Bryant-Waugh, Turner, East, & Gamble, 2007; Bryant-Waugh, Turner, Jones, & Gamble, 2007; A. Stein, Woolley, Senior, et al., 2006). The psychological stressors of motherhood combined with ED, may lead to depression, which can lead mothers to be nonresponsive, inconsistent, or rejecting toward their infant, placing the mother-baby attachment at risk (Astrachan-Fletcher, Veldhuis, Lively, Fowler, & Marcks, 2008). More symptoms of anxiety and depression has also been shown among women who have BN in pregnancy compared to pregnant women without ED in a large Norwegian population study (Knoph Berg et al., 2008; Mazzeo et al., 2006; Micali et al., 2007).

Difficulties with feeding and reduced infant growth have also been reported in the population of ED (A. Stein, Woolley, Cooper, et al., 2006). Mothers with ED have shown to have difficulties in the management of feeding (Stapleton, Fielder, & Kirkham, 2009; Tierney, Fox, Butterfield, Stringer, & Furber, 2011), leading to mothers' distress over time (Micali, Simonoff, Stahl, & Treasure, 2011). In particular some mothers with ED are particularly controlling over their child's behaviour in both feeding and play (A. Stein et al., 2001).

ACTIVITIES OF DAILY LIVING

Most often, activities of daily living (ADL) is separated into two categories; basic activities of daily living (BADL) and instrumental activities of daily living (IADL) (Stedman, 2012). While BADL focus on activities involving care of the self, IADL involves more complex activities which require interaction with the environment, for example grocery shopping and use of public transportation. Many parents with ED report that they have difficulties with IADL due to their ED. For instance, many of the parents describe that their fear of interacting with people in settings where food is served have led them to avoid

their children's school plays or other school-related events. Also, restrictive eating patterns or purging behaviours create problems with adequate food intake in both the parents and their children. For some parents, ED severely disrupts family mealtimes and some parents describe never having had a meal with their children. Moreover, both the parents and their children describe disrupted routines of daily living in their families due to the ED. Our experience is that parents with ED have difficulties with IADL which compromises the dynamic in the family.

THE HEALTH PERSONNEL ACT § 10A

In Norway, the Health Personnel Act § 10a defines the duty of health personnel to help protect minors as relatives («Health Personnel Act § 10a », 2009). This legislation describes the duty that health personnel have to help safeguard the need for information and provide necessary support that minor children of patients with mental illnesses, drug addiction or severe physical illness or injury may have due to the parent's condition. Earlier, the challenges children and their families had due to the parent's condition were not sufficiently addressed, leaving thousands of families without adequate treatment and support. Thus, it is important to tailor and incorporate specific treatment programs for parents with ED. Since parenting is so central for children's development and later functioning, it is of utmost importance that mental health professionals acquire knowledge and methodology to strengthen parenting skills. That way, we as health care professionals can help prevent future generation difficulties in children of parents with ED.

AIM

In this article, I will describe a tailored and individualized in-patient treatment program for parents or pregnant women with ED. Only the elements pertaining to the parent aspects are described here. Other key elements of the ED program at this ED unit is not covered in this article. This parent program for patients with ED is aimed at strengthening parenting skills and prevent relapse of ED symptoms due to challenges of parenthood in combination with their illness.

Some key elements inform this treatment program:

1 attachment theory
2 the psycho-educative parenting program Circle of Security Parenting (COS-P) (Hoffman, Marvin, Cooper, & Powell, 2006)
3 the «Children's Hour» (Haukø & Stamnes, 2009)
4 qualitative studies of ED and parenthood (Eik-Nes, 2011; Taborelli et al., 2016)
5 clinical experience with ED and parenthood

THEORETICAL FOUNDATIONS OF COS-P:

The theoretical foundation of COS-P is Bowlby's attachment framework (Bowlby, 1997) where the theory is that children are most likely to develop a secure attachment when they have confidence in an attachment figure to whom they can return as a safe haven for comfort when distressed, and then use as a secure base from which to confidently explore. The main goal of COS-P is to help parents improve parenting through increased ability to mentalize the child. In the COS-P intervention, focus is on caregiver's secure base which leads to an emphasis on sensitive responsiveness to the child. The intervention focuses on teaching parents a sensitive response to a child's distress aimed at fostering the child's use of the caregiver as a safe haven. Substantial data indicate that negative and atypical caregiving responses to distress are linked to insecure and disorganized attachment and psychopathology (Gedaly & Leerkes, 2016).

METHODS

This report was made as a part of a larger thematic publication on «Mental health and Addiction» by the Norwegian Occupational Therapy Association.

All patients with ED who are pregnant or have children are offered this tailored in-patient treatment parent program. The tailored program is given irrespective of their children's ages. Also, parents who have lost custody of their children are offered this program. No patients have declined to follow this program while in treatment.

The patients have at assessment been given an ICD-10 diagnosis of either anorexia nervosa, bulimia nervosa or Eating Disorders Not Otherwise Specified (EDNOS) (WHO, 1992) or Binge Eating Disorders (BED) (*Diagnostic and statistical manual of mental disorders: DSM-IV-TR*, 2000) classified according to the DSM IV research criteria.

SETTING

This unit for ED offers a specialized in-patient treatment program for adult men and women who suffer from ED. This specialized centre in Stjørdal at Levanger Hospital serves the region of Mid-Norway, but offers treatment to all the health regions in Norway

due to *free hospital choice* in Norway. The unit aims to assess, diagnose and treat patients with long term and severe ED. The ED treatment program at our hospital uses contracts, based on the notion that ED are an inexpedient way of coping with emotional problems. The unit at Stjørdal has eight beds/rooms and an apartment. The parent program includes early and relatively long leaves during the in-patient treatment, which give them the opportunity to have longer periods at home with their families while admitted. Housing for the family is provided when needed. The patients are offered treatment in sequences of various lengths due to severity of illness. The length of stay is decided by a team of experts by reaching a consensus.

In the time period between 2003 and 2015 (12 years), a total of 1,618 patients have been referred for treatment at RKSF, Levanger Hospital. Mean age of the patients at the time of referral was 27.5 years (95 percent CI, 27.02-28.01). The ages at referral ranged from 13.2 to 66.5 years old. Of all women with an ED given right to treatment in this time period (n=1,095), (34.9 percent) had given birth to a child before February 2015.

ORGANIZATION OF THE PARENT PROGRAM

Unit for ED, Stjørdal at Levanger Hospital have since 2011 tailored treatment for parents with ED. Five members of the staff form a team specifically working with parents and pregnant women with ED while in treatment. The team leader is an occupational therapist with a MSc in Child and Adolescent Mental Health. Two of the team members are clinical psychologists, and two team members are nurses who have been trained in the Norwegian «Advanced Programme in Mental Health Care». Two of the team members are certified COS-P therapists.

All patients are given information about the background for this tailored program for parents with ED at the unit upon admission. Close collaboration with the patient's treatment team is highlighted due to strong affects in exploring parenthood.
The «parent program» at the unit consists of

1 a weekly session with parents/pregnant women with ED
2 at least one individual session with psychologist or doctor where aspects of parenthood are targeted when needed
3 session with patients' children
4 group sessions and individual sessions with caregivers, spouses and children
5 individual consideration of trauma experiences

As of 2016, the «parent program» was strengthened with the addition of COS-P (Hoffman et al., 2006) and the «Children's Hour», which is a preventive Norwegian health care program for children who have parents with mental and/or substance problems (Haukø & Stamnes, 2009). All children of the parents in this program are given the opportunity to participate in «The Children's Hour». Two of the team members have received extensive training and supervision in this method which includes sessions with children and information and query time for all children from two to 18 years old who have their parents, siblings or other caregivers admitted to treatment.

WEEKLY GROUP SESSION

In the weekly group session, we aim to give the parents tools to develop or enhance their vocabulary and framework for observation and reflection to support their understanding of themselves and their children, and how this influences their ED.

Primarily, we aim to give the parents tools to recognize and understand the different forms of attachment related needs that their children's can have.

The weekly group session consists of no more than six participants and lasts 45 minutes. The groups are« slow-open» as patients have various lengths of treatment periods. Two therapists lead the group.

The sessions are largely based on qualitative research and patients' experiences with ED and parenthood (Eik-Nes, 2011; Taborelli et al., 2016). The following themes appear to be typical for patients with ED and are thus covered in the group:

1 having a guilty conscience as a mother
2 food preparation
3 feeding and interactions around mealtimes
4 not receiving adequate help in their pregnancy
5 fear of gaining weight or changing form
6 fear of harming their child
7 lack of energy as a mother
8 difficulties transferring coping skills

Themes specifically relating to pregnancies and the post-partum period are also covered:

1 approaching pregnancy: not expecting to be pregnant
2 early pregnancy: a difficult transition, making space for the baby: the sacrifice of the ED identity

Patients are in the group given the opportunity to observe, describe and explore their child's unique temperamental characteristics.

3 middle to late pregnancy: assuming the pregnancy identity, a new body to love
4 post-partum: loss of the pre-pregnancy body identity, loss of pregnant identity
5 other pregnancies

Within each theme, particular challenges, difficulties and thoughts are identified by the patients and explored together with the members of the group and therapists. In addition to these ED specific themes, related aspects targeting maternal sensitivity as a means of influencing child attachment are explored (Cassidy & Shaver, 2016). Patients are in the group given the opportunity to observe, describe and explore their child's unique temperamental characteristics. Subsequent, we aim to help the parents observe, recognize and understand the different ways their children's behaviors induce specific thoughts and feelings in them, specifically emphasizing specific thoughts and feelings related to their ED. Next, these ED related thoughts are explored in terms of how these thoughts influence their behaviors and consequently their children. It is earlier stated that such insight is particularly important for parents who have experienced trauma or atypical caregiving in their own childhoods, as is the case for many of the parents in our unit. When the patients have been given a framework for observation and reflection, a foundation is set for reflective dialogue concerning parenthood and the unique experiences of having an ED.

EXPERIENCES WITH THE PARENT PROGRAM

As earlier stated, patients with children in all age ranges, including pregnant patients, are offered this parent program. Excluding mothers due to having

children over the age of 18 is deemed unfortunate as many patients report years of guilt due to their ED throughout their children's childhood. We view difficulties with parenthood to be a maintaining factor for ED. Thus, the experience of including patients with children of all ages are regarded as highly positive. Health personnel report that the patients are highly satisfied with the program's use of the key elements from the COS-P intervention such as «*the Circle of Security*» (Hoffman et al., 2006). Many parents also report that they similarly have benefited using the techniques learned with their partners and other loved ones. Educational tools such as Disney's «Inside out» (Docter, 2015) and a board game called «Hi - a game about feelings, thoughts and situations» have been used with both parents, children and grand-children to explore thoughts and feelings (Sommerseth & Winsnes). This board game was developed as a tool to facilitate communication with children in an age appropriate way (Olsen, Winsnes, & Svendsen, 2013). Engaging and motivating children and adolescents in psychotherapy can be a challenge for therapists. Because a child's mental health largely is influenced by the parents, evaluation of the children's home, school environment and community life has been emphasized in this parent program. Occupational therapists are encouraged to involve parents, teachers, nurses at schools and other important health professionals in therapy (Brown & Stoffel, 2011). The «Hi-game» has been applied to this parent program to help both the parents and the children communicate thoughts and feelings relating their home and school environment and community life with emphasis on how the ED affects the family. All patients have been given the «Hi game» to take home to support and increase communication of thoughts and feelings in the family.

Some couples have been offered the full COS-P intervention, when considered necessary in addition to the parent program described here.

Consistent with finding from a qualitative study on mothers with ED, experiences with this program reveal that women with ED largely have not had any support from health personnel regarding their challenges in pregnancy and motherhood (Eik-Nes, 2011).

Patients describe that the group experience is especially helpful in their treatment, as being a parent with an ED is a unique lived experience that is best understood by other parents with ED. Patients' also emphasize satisfaction with the program's elements on «conversations with their children, spouses and extended family about ED» and how these influence the family dynamic. Due to the shame and stigma related to ED, many of the mothers have not participated in maternity groups and thus been given the possibility of discussing «normality» of parenting. Therefore, elements from COS-P and attachment theory has been beneficial in supporting patients in general parenting skills.

This intervention has showed us the significance of addressing concerns about ED and parenthood, with specific consideration to the guilty conscience of parents. Participants in the group intervention describe shame and embarrassment of having an ED in combination while being a parent, and that they consequently did not attend general parenting groups offered in the health care system. Our main experience is that reflecting upon the included themes helps the patients support their own children in their negative affects and decrease the feeling of shame. Likewise, patients are been taught to better communicate their needs of emotional support from their spouses or other caregivers.

CONCLUSION AND CLINICAL IMPLICATIONS

Health care professionals should offer individual or group support to women in an environment with knowledge of ED. Parents with ED and consequently their families seem to feel supported by just bringing the experiences with pregnancy and parenthood into the discourse in the treatment settings. Even though some patients are hesitant to talk about challenges with parenthood, most patients describe a relief when given the opportunity to talk about difficulties with parenthood and ED in a safe and structured way.

The complexity of having an ED and being a parent is best treated with a designated team who have an understanding of this complexity. A designated team of health professionals have been of significance as both general parenting skills and aspects specific to ED are unique and challenging for this group of patients.

Knowledge on which themes to address in this intervention and most importantly, how to address these themes have been vital in our approach.

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