Interventions to Empower Adults with Eating Disorders and Their Partners around the Transition to Parenthood

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The transition to parenthood is perceived as a stressful life event, when parents experience an immense change of their psychological focus and a reorientation of roles and responsibilities in the family system. This process may be even more challenging in the presence of a parental eating disorder history. This paper reviews the impact of parental eating disorders on the parents, the couple relationship, and their child during the perinatal period. A parental eating disorder is associated with more negative expectations of parental efficacy as well as specific difficulties in couple communication over the child's feeding, shape, and weight. Providers who better understand the effects of an eating disorder on parental functioning can more effectively intervene early on. We also present couple- or parent-based, empirically supported interventions for adults with eating disorders and their partners in the prenatal and postnatal periods: Uniting Couples in the treatment of Anorexia Nervosa (UCAN) and Uniting couples In the Treatment of Eating disorders (UNITE) both enhance recovery from the eating disorder through a couple-based intervention; the Maudsley Model of Treatment for Adults with Anorexia Nervosa (MANTRA) incorporates the support of partners, when appropriate; Parent-Based Prevention (PBP) focuses on improving parental functioning and reducing risk of negative parental and child outcomes. Finally, we discuss the clinical implications of addressing parental eating disorders and encourage more research on these families.

Keywords: Couples; Eating Disorders; Marriage and Family Counseling; Parent-Based Prevention; Transition to Parenthood

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The transition to parenthood is both a joyous and a stressful life event. Although a new child often inspires feelings of love and closeness between the new parents, couples

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also report increased conflict and feelings of inefficacy (Perry-Jenkins, Goldberg, Pierce, & Sayer, 2007). Such experiences may be due to biological, psychological, and interpersonal changes that accompany the transition to parenthood. These changes may serve as catalysts for individual and family growth (Johns & Belsky, 2007) or lead to a maladaptive interactional style within the family with broad consequences for both parents, their relationship, and the development of the child (Perry-Jenkins et al., 2007). In the context of eating disorders, these varying biopsychosocial changes may facilitate recovery in some while exacerbating (or re-igniting) symptoms in others (Watson et al., 2013). Thus, couples with personal histories of eating disorders may face unique challenges in their role as partners and parents.

Eating disorders are severe mental illnesses associated with high mortality, affecting an estimated 3.5–6.5% and 3–3.5% of Western world women and men, respectively (Allen, Byrne, Oddy, & Crosby, 2013; Hoek & van Hoeken, 2003; Hudson, Hiripi, Pope, & Kessler, 2007; Raevuori, Keski-Rahkonen, & Hoek, 2014). Eating disorders are not limited only to the American continent and Europe, and have been documented in Asia and developing Middle-Eastern countries (Galmiche, Déchelotte, Lambert, & Tavolacci, 2019). The main diagnoses in this classification include anorexia nervosa (AN), bulimia nervosa, binge eating disorder (BED), and avoidant/restrictive food intake disorder (ARFID; American Psychiatric Association, 2013). The development of eating disorders is due to a complex interplay of genetic, biological, and psychosocial circumstances; factors that may precipitate and perpetuate these illnesses include the internalization of the thinness ideal, difficulties in distress tolerance, anxiety, and depression (American Psychiatric Association, 2013). Despite the existence of empirically supported, effective interventions, 49% of men and 68% of women with eating disorders ever seek professional help for their symptoms (Mohler-Kuo, Schnyder, Dermota, Wei, & Milos, 2016). Since a significant number of individuals experience an eating disorder in child-bearing years, it is important to guide professionals in their work with this population and offer direction for advancing the field. Of note, the transition to parenthood has been mostly studied in heteronormative couples where the individual with the eating disorder was the mother. Therefore, scant research exists on whether many of the reported observations apply to fathers with eating disorders and to other couple and parenting configurations such as adoptive, LGTBQ, and single parents (Sadeh-Sharvit & Lock, 2018). With this caveat in mind, we review the literature and describe couple-based interventions that work to strengthen spousal support, mitigate parental psychopathology, and improve child outcomes.

TRANSITION TO PARENTHOOD

Parenthood is a significant adult milestone. Expectations of how satisfied and successful parents will feel in their new role, the prenatal couple relationship, parental psychopathology, and contextual factors (e.g., financial status, intentional pregnancy) influence the transition to parenthood (Lawrence, Nylen, & Cobb, 2007). Several developmental tasks during the perinatal period are particularly challenging in the presence of an eating disorder. During the prenatal period, the expectant mother is the direct caregiver of the fetus, which contributes to a sense of responsibility and closeness, but can also introduce new concerns and preoccupations and—in some primiparous mothers—diminished tolerance for negative emotions (Behringer, Reiner, & Spangler, 2011; Ben-Ari, Ben Shlomo, Sivan, & Dolizki, 2009; Stern, 1995). These psychological processes are associated with several postnatal outcomes, including maternal well-being, mother–infant bonding, and fetal growth and development (Fonagy, Steele, & Steele, 1991; Kluwer, 2010). Increased prenatal maternal stress—stemming from an imbalance between maternal stressors and maternal resources, for example, environmental conditions, social support,

and psychological well-being—is associated with maladaptive emotional responses and behaviors, such as smoking and poor nutrition and even preterm labor (Beydoun & Saftlas, 2008). Further, significant hormonal fluctuations are experienced during pregnancy, including increases in levels of estrogen and progesterone by 100- to 1,000-fold, both of which decline sharply following childbirth (Klier et al., 2007). These dramatic changes may precipitate postnatal depression and emotional difficulties in vulnerable new mothers (Schiller, Meltzer-Brody, & Rubinow, 2015). Additionally, during and after pregnancy, a woman's body necessarily increases and then decreases in size; in cultures where thinness and athleticism are idealized, these changes to shape and weight may be particularly troubling for a new mother (Abraham, 1998; Astrachan-Fletcher, Veldhuis, Lively, Fowler, & Marcks, 2008).

Due to the centrality of the new identity of motherhood, this process can facilitate personal growth in a new mother (Nelson, 2000), while also producing anxiety over maternal efficacy in this new role. This process is exacerbated by socially constructed standards of femininity and motherhood (Besser & Priel, 2003; Ruble et al., 1990). Additionally, women with pre-existing mood, anxiety, distress tolerance, and substance use disorders—conditions that co-occur in approximately 56% of individuals with AN, 95% of individuals with BN, and 79% of individuals with BED (Hudson et al., 2007; Preti et al., 2009)—report symptom increase during pregnancy (Howard et al., 2014). This worsening of symptoms makes some women with eating disorders more vulnerable to distress after childbirth, including problems adjusting to motherhood and poor self-care (Koubaa, Hallstrom, & Hirschberg, 2008; Lai, Tang, & Tse, 2006; Watson et al., 2014).

The perinatal period is both an exciting and challenging time for new fathers as well (Condon, Boyce, & Corkindale, 2004). The developmental changes they undergo partly overlap with their partners' changes, but their own experience could be overshadowed by the more noticeable transformations that the mothers experience (Habib, 2012). The earliest stages of this process require new fathers to assume a role when they are not directly involved with the major events entailed of pregnancy, childbirth, and breastfeeding (Bradford & Hawkins, 2006; Schulz, Cowan, & Cowan, 2006). Therefore, fathers face the challenging task of confronting feelings of exclusion and inefficacy, while simultaneously providing support to their partners and devoting mental resources into developing father-infant attachment and paternal competency (Sevigny, Loutzenhiser, & McAuslan, 2016). Partners also report a particular set of challenges postpartum, namely work- and sexual-related performance concerns, higher distress during and after pregnancy, adjustment to changes in the marital relationship, and feelings of jealousy toward the mother–infant relationship (Condon et al., 2004). As the gender roles evolve and become more flexible, new fathers feel they need to search harder than their female partners for models of male nurturance and paternal competency (Sevigny, Loutzenhiser, & McAuslan, 2016).

The transition to parenthood is a major life event and a stressor that rearranges parents' roles, rules, and responsibilities (Johns & Belsky, 2007). However, models studied on heteronormative families may be modified for understanding single-parent, adoptive, and same-sex families (Sadeh-Sharvit & Lock, 2018). For instance, partnership status can impact parental enjoyment of parenthood: Sole parents report greater stress, negative emotions, and fatigue, compared to partnered parents (Meier, Musick, Flood, & Dunifon, 2016). Additional characteristics such as unemployment, low socioeconomic status, and minority group identification might also add additional strain on new parents and serve as barriers to seeking instrumental and emotional support (Nelson, 2000). When gay and lesbian parents experience greater acceptance by their extended family, workplace, neighborhood, and state, they report better adaptation (Goldberg & Smith, 2011). Likewise, adoptive parents may need to adjust to inter-racial and cross-cultural differences in the new family, requiring greater mental resources invested into the perinatal phase.

EATING DISORDERS AND THE TRANSITION TO PARENTHOOD

Prior to the birth of a child, the family system consists of one reciprocally influencing relationship between partners. Postpartum, three reciprocal relationships emerge, each of which contributes to the development and maintenance of the family system and the satisfaction of other parties of this triadic relationship (Johns & Belsky, 2007). Since mental resources are partly directed at managing the mental disorder and coping with the challenges of life (Nicholson, Sweeny, & Geller, 1998), some parents with psychiatric illnesses may have a diminished sense of perceived parental efficacy, possibly feeling less optimistic about their parental competencies (Jones, O'Connell, Gound, Heller, & Forehand, 2004). Additionally, many parents with histories of mental illness fear that their children will be genetically predisposed to have similar difficulties, which further complicates parental confidence and self-assessment (Patel et al., 2002).

The quality of the prenatal couple relationship predicts postnatal parental child engagement for both mothers and fathers, particularly during the infant to toddler years (Belsky, Youngblade, & Pensky, 1989; Cohn, Cowan, Cowan, & Pearson, 1992). However, this association appears to be unidirectional: Marital quality predicts parental involvement, not vice versa (Carlson, Pilkauskas, McLanahan, & Brooks-Gunn, 2011). Further, parental mental disorders are associated with adverse parental and child outcomes (Stein et al., 2014), reinforcing the importance of early identification of parental psychopathology and its impact on child-rearing practices.

Evidence suggests that mothers with eating disorder histories represent a unique and vulnerable patient population that must be understood in the context of their psychopathology as well as their parental role and responsibilities (Bryant-Waugh, Turner, East, & Gamble, 2007; Sadeh-Sharvit, Levy-Shiff, Arnow et al., 2015; Sadeh-Sharvit, Levy-Shiff, Feldman et al., 2015; Taborelli et al., 2016; Watson et al., 2014). Pregnancy and childbirth differentially impact women's eating disorder symptomatology: While 29–78% of women achieve full remission from their eating disorder during pregnancy, 5–8% of pregnant women still have active symptoms or develop an eating disorder during pregnancy (Bulik et al., 2007; Micali et al., 2014; Watson et al., 2013). Eating disorder presentation postpartum is variable as well; some women experience sustained or new-found relief from eating disorder symptoms, whereas others are triggered by the focus on their bodies, their role in feeding their young children, and the pressures of motherhood, all of which can lead to relapse or continued engagement in eating disorder behaviors (Blais et al., 2000; Conrad, Schablewski, Schilling, & Liedtke, 2003; Crow, Agras, Crosby, Halmi, & Mitchell, 2008; Sadeh-Sharvit et al., 2016).

Mothers with eating disorders, past or present, report more pregnancy-related complications and emotional difficulties, including a heightened risk for postpartum depression and anxiety (Kimmel, Ferguson, Zerwas, Bulik, & Meltzer-Brody, 2016). They experience an increased focus on their weight and shape, both personally as well as from family, friends, and medical professionals, compared to their noneating disorders counterparts (Newton & Chizawsky, 2006; Patel, 2002). Physical changes postnatally, combined with changes in their energy needs and greater awareness of their bodies, force mothers to relinquish some of the eating- and body-related behaviors they previously used to regulate their emotions and respond to stress (Abraham, 1998; Micali, Simonoff, Stahl, & Treasure, 2011; Patel, 2002; Taborelli et al., 2016). However, the elimination of these emotion regulation strategies may precipitate greater stress. Additionally, pregnancy-related hormonal changes greatly impact emotions and food cravings, which can further complicate the reciprocal relationship between pregnancy, the changing body, eating, and mood (Kimmel et al., 2016). Maternal eating disorders are also associated with earlier termination of breastfeeding (before 6 months postpartum), greater feeding difficulties, and reported

greater challenges in mother–infant bonding and enjoyment of motherhood (Koubaa et al., 2008; Lai et al., 2006; Stein, Woolley, & McPherson, 1999; Torgersen et al., 2010). These complications in the transition to motherhood are associated with decreased perceived maternal efficacy, and early-onset feeding and eating problems as well as weight abnormalities in the children of these individuals (Blissett, Meyer, & Haycraft, 2006; Squires, Lalanne, Murday, Simoglou, & Vaivre-Douret, 2014). Pilot data suggest that both female and male parents with BED report similar feeding difficulties in their children (Lydecker & Grilo, 2016). Nevertheless, despite the greater stress described by mothers with eating disorder histories, the transition to motherhood and the well-being of the child are motivating and maintaining forces for recovery (Blais et al., 2000; Bulik et al., 2007; Patel et al., 2002; Sadeh-Sharvit et al., 2016).

PARTNERS OF INDIVIDUALS WITH EATING DISORDERS: CHALLENGING SPOUSAL SUPPORT

Spousal support is essential for parental functioning. Due to the secretive and insidious nature of eating disorders, partners are often unaware of the presence, severity, or course of the patient's eating disorder symptoms (Bulik, Baucom, Kirby, & Pisetsky, 2011; Linville, Cobb, Shen, & Stadelman, 2016). Additionally, partners commonly report trust issues, isolation, confusion, and difficulty understanding the disorder (Huke & Slade, 2006). Despite this lack of awareness of symptoms, partners typically feel pressured to monitor their loved one's behavior and be an agent of change, but do not know how to effectively do so. With perceived ineffective supportive attempts, feelings of powerlessness and responsibility for relapses present for some partners (Linville et al., 2016). Accordingly, many partners report considerable distress. In fact, caregiver burden is higher in eating disorders than in other serious psychiatric disorders, including schizophrenia and depression (Fischer, Baucom, Kirby, & Bulik, 2015; Graap et al., 2008; Treasure et al., 2001; Zabala, Macdonald, & Treasure, 2009).

When partners experience such challenges in receiving and providing support, ineffective communication patterns can develop (Sadeh-Sharvit, Levy-Shiff, Arnow, & Lock, 2015). Some partners become avoidant due to fear of saying or doing something counterproductive, whereas others become critical or blaming, for instance when expecting that their partner would fully and quickly recover from their eating disorder (Huke & Slade, 2006; Linville et al., 2016). For instance, partners of individuals with BED may accommodate their symptoms, for example, enable and reinforce cognitions and behaviors associated with the eating disorder, in an attempt for emotional coregulation (Weber et al., 2018). These patterns can inadvertently reinforce or exacerbate the eating disorder symptoms as well as its shame, secrecy, and self-critical nature, creating a damaging interactional cycle (Arcelus, Haslam, Farrow, & Meyer, 2013; Linville et al., 2016). Thus, typical difficulties involved in the transition to parenthood may be intensified in the context of a maternal eating disorder (Bradford & Hawkins, 2006; Sadeh-Sharvit & Lock, 2018; Sevigny et al., 2016; Squires et al., 2014), thereby potentially leading to decreased parental involvement and partner support, both of which are crucial to the maintenance of the family system in general, and the child's development in particular (Cimino, Cerniglia, & Paciello, 2015; Epstein & Baucom, 2002).

COUPLE-BASED INTERVENTIONS FOR ADULTS WITH EATING DISORDERS AS THEY TRANSITION TO PARENTING

Given the associations among parental eating disorder, couple relationship quality, and child and family outcomes, early family-based interventions utilizing the couple to target

the individual with the eating disorder are critical to adequately supporting these families (Howard et al., 2014; Velders et al., 2011). Whether in pregnancy or not, most individuals in committed relationships who are recovering from eating disorders report relying on their partners for support in their recovery (Linville et al., 2016; Tozzi, Sullivan, Fear, McKenzie, & Bulik, 2003). Further, a couple-based program provided during the perinatal period can decrease the extent of marital dissatisfaction following the transition to parenthood, thus improving family relationships early on (Schulz, Cowan, & Cowan, 2006). As such, pregnancy and the postpartum period may be ideal times for family-based early interventions that target a parental eating disorder and the difficulties it may present for a new family. Therefore, a few interventions have been developed, manualized, and studied to address this sensitive period. These programs are offered as stand-alone interventions at a developmental phase when the system is ready for change, either when the couple system has become more committed, or after the birth of a child. These interventions incorporate psycho-education on eating disorders, support to the couple as they adjust and improve their communication patterns, emotion regulation skills through active skill building, and assistance in problem-solving regarding child feeding, eating habits, and family body talk (see Table 1 for a summary of interventions designed for adults with eating disorders and their partners).

Two specific interventions to support the couple in addressing AN (Uniting Couples in the treatment of Anorexia Nervosa, UCAN) and binge eating type disorders (Uniting couples In the Treatment of Eating disorders, UNITE) have been empirically tested (Bulik, Baucom, & Kirby, 2012; Bulik et al., 2011; Runfola et al., 2018). These interventions integrate enhanced cognitive behavioral couple therapy and cognitive behavioral therapy for eating disorders, while drawing from dialectical behavioral therapy techniques, to help couples reach joint decisions about treatment and recovery while attending to their developmental phase, role transitions, and environmental demands. They target the eating disorder and reduce stress by improving communication around its symptoms (Target 1), enhancing interpersonal problem-solving/behavioral change skills (Target 2), and improving emotion regulation skills (Target 3). In doing so, couples are taught how to address mealtimes, manage triggers (e.g., stress, holidays, body comments), and effectively respond to eating disorder urges and behaviors (e.g., restriction, binge eating, purging) while building support, trust, and open communication within the relationship. Partners can also bolster the therapeutic process when discussions of the need for more intensive treatment for the individual with the eating disorder are warranted (Kirby, Baucom, La Via, & Bulik, 2016). Results from open trials of UCAN and UNITE (Baucom et al., 2017; Runfola et al., 2018) report a substantially greater weight gain (M_{BMI} increase of 2.9) and higher recovery rate (of 25%) in AN patients and a high binge eating abstinence rate (of 78%) in BED patients by the end of treatment, compared with clinical trials in which adults with eating disorders received individual treatment that did not include their partner's involvement (Berkman et al., 2006; Brownley et al., 2016; McIntosh et al., 2005; Zipfel et al., 2014). Both trials also provide preliminary support for couple-based interventions positively reducing eating disorder (i.e., shape and weight concerns) and comorbid psychopathology (i.e., depression and anxiety symptoms) as well as improving emotion regulation and communication in both partners (Weber et al., 2018). Moreover, as low dropout rates of ~10% were observed across both trials, encouragement from partners might help keep patients in treatment. Overall, although preliminary, these findings suggest that including a partner in treatment might positively influence eating disorder and couple-related outcomes. In the context of couples in the perinatal period, UCAN and UNITE can be modified to address specific challenges and possible stumbling blocks that new parents may encounter. For example, unique stressors to this life-cycle transition may need to be discussed to reduce the individual's exposure to parenting-related

TABLE 1

Empirical Support for Interventions to Empower Adults with Eating Disorders and Their Partners

Intervention	Publication(s)	Therapy Goal	Participants	Study Design	Empirical Findings
A. Interventions exclusively designed for individuals with eating disorders and their partners					
Uniting Couples in the treatment of Anorexia Nervosa (UCAN)	Baucom et al. (2017)	A couple-based intervention for adult AN to augment the effects of standard care	20 couples in which one partner had AN. 11 couples had children	Case series: 13 couples received the UCAN program while 7 received supportive couple therapy. Both treatments delivered in an outpatient setting as adjunct to individual therapy for 22 sessions	Patients improved at post-treatment and 3-month follow-up on various AN-related measures, anxiety and depression, and relationship adjustment. Partners also improved on anxiety, depression, and relationship adjustment Compared to individual treatment for AN, benchmarking analyses revealed multicomponent couple treatment had comparable outcomes on AN-related outcomes but lower dropout rates. Dropout rate was 10%
Uniting couples In the Treatment of Eating disorders (UNITE)	Runfola et al. (2014)	A couple-based intervention for adult BED to augment the effects of standard care	11 heterosexual couples in which one or both partners had full- or subthreshold BED	Case Series: all couples received UNITE for 22 weekly sessions in an outpatient setting as adjunct to individual therapy. 3-month follow-up	Patients' eating and depression scores improved as well as emotional regulation at both time points. Both patients and partners reported improvements in affective communication. Both patients and partners remained relationally satisfied across time points Dropout rate was 9%

TABLE 1
Continued

Intervention	Publication(s)	Therapy Goal	Participants	Study Design	Empirical Findings
Parent-Based Prevention (PBP)	(1) Sadeh-Sharvit, Zubery, Mankovski, Steiner, and Lock (2016) (2) Sadeh-Sharvit, Runfola, Welch, and Lock (2015)	A parenting program designed for parents with eating disorder histories that incorporates partner's involvement	(1) 16 parents with eating disorders and their partners. (2) 24 parents with eating disorders and their partners. In both studies, participants were parents of children 1–5 years old	(1) Case Series: 16 mothers received PBP over 24 sessions: 12 group treatment sessions and 12 family treatment meetings. (2) RCT: 24 mothers randomized to a 12 session, couple-based PBP or usual care.	In both trials, mothers showed improvement in feeding behaviors, eating and comorbid symptoms, and child behaviors. Both studies reported 25% dropout
B. Interventions uniquely designed for adults with eating disorders that have been studied in at least one randomized controlled trial and include couple sessions					
Maudsley Model of Treatment for Adults with Anorexia Nervosa (MANTRA)	Schmidt et al. (2016)	A cognitive-interpersonal intervention for adult AN Patients are encouraged to involve their support system in treatment, including partners	142 adults with AN	RCT: participants randomized to either MANTRA or specialist supportive clinical management (SSCM) over 24–34 weekly sessions. 24-month follow-up	Patients in both MANTRA and SSCM BMI significantly increased while eating disorder and comorbid significantly decreased by 24-month follow-up in both treatments. MANTRA was rated as more acceptable and credible than SSCM at 12-month follow-up Those receiving MANTRA had greater treatment completion rates. Findings showed a nonsignificant trend greater increase in BMI favoring MANTRA. However, in both groups 83% of participants did not seek additional intensive treatment post-trial 25% dropout in MANTRA versus 41% in SSCM

TABLE 1
Continued

Intervention	Publication(s)	Therapy Goal	Participants	Study Design	Empirical Findings
Family Therapy	Dare, Eisler, Russell, Treasure, and Dodge (2008)	Family treatment for adults with AN aims to limit the impact of the eating disorder on family transactions. At least two thirds of number of sessions included partners or other family members	84 adults with eating disorders (average age 26.3, illness duration was 6.3 years), 20 of whom had partners	RCT comparing family therapy, psychoanalytic psychotherapy, cognitive analytic therapy, and low-contact case management. Interventions were provided over 7-12 months, with 1-year follow-up	All interventions showed modest effects; however, family therapy and psychoanalytic psychotherapy were superior to the other conditions in reducing AN symptoms and increasing body weight. Approximately 24% of participants dropped out of family therapy, while the overall dropout rate in the studies was 35%

Note. AN = anorexia nervosa; BED = binge eating disorder; RCT = randomized controlled trial.

emotion-driven eating disorder triggers (e.g., discord over child discipline practices or beliefs of not being a "good enough" parent) and/or to continue focusing on eating disorder recovery.

Parental eating disorders have particularly strong implications for the development of adaptive child feeding and eating patterns, as well as functional family interactions around food (de Barse et al., 2015; Hoffman et al., 2014; Lydecker & Grilo, 2016; Stein et al., 2006). Consequently, the Parent-Based Prevention (PBP) of Eating Disorders, a focused intervention for parents with eating disorders and their partners, concentrates on enhancing parental efficacy and couple communication to reduce the risk of problems in feeding and the parent-child relationship (Sadeh-Sharvit & Lock, 2018; Sadeh-Sharvit, Runfola, Welch, & Lock, 2019; Sadeh-Sharvit, Zubery, Mankovski, Steiner, & Lock, 2016). In PBP, the therapist works with the couple to identify their family's specific challenges, and guides the parents to improve problematic cognitions, emotions, and behaviors associated with the aforementioned risks. The individualized approach of PBP addresses three mechanisms theorized to precipitate and maintain the challenges observed in families headed by a parent with an eating disorder history: unhealthy feeding practices, impact of parental co-occurring mental difficulties, and parental communication patterns. When PBP is provided at an early stage of the parental role formation, parents can develop and practice more adaptive child-rearing cognitions and behaviors before problematic parenting styles become entrenched patterns (Sadeh-Sharvit et al., 2016). Further, the model addresses the characteristics of the child as well as the involvement of extended family members, and their reciprocal effects on the couple and parental functioning. Completion of PBP is associated with more positive parental views on the child, and reduced maternal eating and comorbid symptoms (Sadeh-Sharvit et al., 2016). A recent randomized controlled trial found that PBP is acceptable for parents, and leads to improved feeding habits, including reduced monitoring of and concern for child's eating as well as fewer restrictive and pressuring feeding behaviors (Sadeh-Sharvit et al., 2019). In addition to the above programs, which were explicitly designed for adults with eating disorders and their partners, we briefly mention interventions that are not couple-based but do include couple sessions in the program, and whose efficacy was examined in at least one randomized efficacy trial. One such intervention, the Maudsley Model of Treatment for Adults with Anorexia Nervosa (MANTRA), aims to improve the outcomes of adults with enduring AN by targeting the individual and interpersonal factors maintaining the disorder. As such, although most sessions in MANTRA are held with the patient, a specific module focuses on actively involving partners in the intervention (Schmidt et al., 2013). MANTRA had demonstrated good acceptability and credibility among patients and is associated with increased body mass index (BMI) and reduced eating disorder and comorbid symptoms at 2-year follow-up (Schmidt et al., 2016). Another promising adaptation of family-based treatment that enlisted the support of family members of adults with AN (including their partners) has also contributed to reduced symptoms in patients (Dare, Eisler, Russell, Treasure, & Dodge, 2001).

CLINICAL IMPLICATIONS

For any new family, adjusting to novel relationships within the family system is a major challenge. An eating disorder poses additional strain on both parents, which further complicates these transitions. When assessing and treating couples during the pre- and postnatal periods, parental psychopathology, perceived parental efficacy, expectations about the new family, and spousal support must all be considered.

Support for individuals with eating disorders needs to begin in adolescence and young adulthood prior to pregnancy. Pediatricians, adolescent medicine physicians, and general

practitioners must be aware that women with all eating disorders, regardless of BMI and menstrual status, are sexually active (Bulik et al., 2010; Micali et al., 2014). The need for such awareness is only highlighted by the significantly elevated risk of unplanned pregnancies in women with AN (Bulik et al., 2010; Micali et al., 2014). This is especially important in young women who menstruate irregularly, as they may consider themselves to be at low risk of becoming pregnant and fail to take adequate measures to prevent pregnancy. In addition, irregular or absent menses can mask early pregnancy, often for several months, denying women the opportunity to improve nutrition, discontinue alcohol, cigarettes, and other drugs, and stop disordered eating behaviors (Bulik et al., 2010). Obstetric nurses and obstetricians need to become familiar and comfortable with discussing eating disorders with their patients. Ensuring adequate psychological, medical, and nutritional support for those with histories of eating disorders may improve pregnancy outcome. Similarly, partners deserve psycho-education, support, and guidance about how best to assist their pregnant loved ones who have suffered from an eating disorder.

Mental health providers who are cognizant of the impact that a parental eating disorder may have on the transition to parenthood can more effectively provide support to new families seeking counsel. With parenthood offering an opportunity to revisit identity and priorities, individuals may find renewed motivation for receiving treatment to address eating and comorbid symptoms, as increasing hope has been recognized as a common factor in effective treatments for eating disorders (Jewell, Blessitt, Stewart, Simic, & Eisler, 2016). Further, a universal observation is that partners often want to help when their loved ones are dealing with an eating disorder, but they have no blueprint for how to proceed (Huke & Slade, 2006; Linville et al., 2016). Moreover, new parents report worrying not only about the impact that disordered eating behaviors during pregnancy could have on the developing fetus, but also how exposure to parental shape, weight, and eating concerns could influence the child's risk of developing an eating disorder themselves. Combined with concerns about genetic transmission, worries can be pervasive. Therefore, working through these topics with both partners together can be crucial for positive outcomes (Sadeh-Sharvit & Lock, 2018).

Clinicians treating families affected by parental eating disorders must be sensitive to the challenges experienced by individual family members. Parents should be interviewed about their mental health concerns and goals in seeking treatment. The clinician then can help the parents identify and differentiate between explicate common—yet perhaps challenging—responses to the couplehood and parenting experience and those that require professional attention and support. The overarching goal of treatment should be to identify and encourage existing areas of strength within the domains of mental health, couple support, and parental functioning, while simultaneously working with the family to improve specific areas of difficulty that are putatively affecting the child and the family system.

CONCLUSIONS

The interval between the formation of a committed, romantic partnership and the transition to parenthood introduces changes that have ramifications for all family members. Given how stressful and challenging this period can be, inadequate attention has been paid to researching parental eating disorders and their effects on the family. Since many of the studies on adults with eating disorder histories, their partners, and their children have been conducted on relatively small samples and often in open trials or case series, we judge the literature to be inadequate to warrant a systematic review or meta-analysis. As sample sizes increase and more trials are reported, a systematic review and meta-analysis will be valuable in providing a more comprehensive outlook on this topic. Additionally,

there is a great need for research on eating disorders within the field of marriage and family therapy. As we do not know how the existing literature on mothers with eating disorders pertains to the parenting experiences of fathers with eating disorders, and adoptive, gay, and single parents, more data are needed to understand and support these populations. Additionally, preparing individuals with histories of or active eating disorders for the aforementioned changes and supporting them throughout the transition to parenthood is imperative. Although couple-focused and family-based treatments for adults with eating disorders are beginning to emerge, they are not yet universally available. Additional clinical efforts for educating and supporting patients and their partners as they prepare for and navigate the parenting transition will address an important gap in care.

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