

# Using group therapy to support eating disordered mothers with their children: the relevance for primary care

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Eating disorders are a crippling and disabling condition. If they become chronic, the emotional, physical and social effects are substantial. The death rate is the highest of all psychiatric illnesses so the need to find prevention strategies is urgent. This research project has three aims, primary prevention of an eating disorder for the child, helping the mother recover and developing a protocol for a group to be used in primary care. Children of mothers with an eating disorder, are a proven 'at risk' group, because children model and internalize their experiences. This project was carried out in a community setting, targeting mothers with an eating disorder who had children under the age of 13. It was argued that if these mothers can be encouraged to change the dysfunctional behaviour they may be passing on to their children, an attempt can be made to break the cycle. This qualitative research pilot project utilized semi-structured interviews before and after 11 weeks of group therapy, with three- and six-month follow-ups. Although the sample was small, the results showed that a group allowed these mothers a safe space for reflection, enabling them to become aware of their behaviour. As a result the mothers implemented changes in response to their children's needs, encouraging healthier development. The pilot was a precursor for a larger study to be carried out and developed within the primary care network.

**Key words:** group therapy; heritability; mother-child relationship; mothers/eating disorders; primary care; primary prevention

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## Introduction

Eating disorders are becoming the biggest psychiatric killer of our time. It is estimated that over 10% of anorexics die from their illness and bulimics are a high risk for suicide (American Psychiatric Association, 1994), yet less than two-dozen prevention intervention studies have been conducted to date (Austin, 2000). Primary prevention is an attempt to intervene prior to the disorder developing, through altering the risk factors (Slade, 1995). The

main risk factors attributed to eating disorders are biological, psychological, familial and sociocultural (Vandereycken and Noordenbos, 1998; Schmidt, 2002). Proactive primary interventions have proved successful in other areas of public and social health (Winter and McDonald, 1997; Austin, 2000) and as psychological and psychiatric disorders are the third most common diagnosis within primary care (Corney and Jenkins, 1995), primary care seems an obvious location for the use of a proactive intervention targeted at primary prevention. This paper will explore the possibilities of primary prevention for the child, by using group therapy to support and educate the mother. It will describe an intervention that was carried out in a community setting. This intervention can be applied to primary care

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and a larger study has been planned for a primary care setting. The ultimate aim of the research is to develop a protocol that can be disseminated and integrated into primary care throughout the UK.

## Risk

It is becoming widely recognized that the children of eating disordered mothers are at high risk of developing an eating disorder themselves (Stein *et al.*, 1994; Scourfield, 1995; Stein, 1995; Hodes *et al.*, 1997; Van der Broucke *et al.*, 1997; Agras, *et al.*, 1999; Waugh and Bulik, 1999). The risk factors not only point to a genetic vulnerability (Holland *et al.*, 1988; Strober, 1991; Stunkard, 1995; Lilenfeld *et al.*, 1998; Collier *et al.*, 1999; Graber *et al.*, 1999; Strober and Bulik, 2002) but also to environmental factors. Part of the developmental process of the infant is to internalize and mirror the mother (Kohut, 1985; Sugarman, 1991; Stern, 1998). Stern (1998) talks of the 'schema-of-being-with-another' which is developed via repeated interpersonal experiences.

Specific elements in the mother–child relationship, have been identified as relevant to the aetiology of eating disorders. Difficulty in achieving individuation and separation and a dysfunctional mother–child relationship are characteristic of eating disorders (Orbach, 1985; Chernin, 1986; Beattie, 1998). Feminist authors suggest that for generations women's inadequate feelings about themselves have been communicated from mother to daughter through body and self-image issues (Orbach, 1985; Rabinor, 1994). If the eating disordered mother brings her unresolved issues into the relationship with her child and her behaviour is an inappropriate or dangerous model, the transmission of these issues and behaviour become more likely. If we can support these mothers in their parenting role and modify their behaviour by dealing with the issues relating to the eating disorder, we might be able to break the cycle of dysfunction.

## Identification

There is a growing incidence of the childhood onset of eating disorders; anorexic symptoms are being identified in children as young as six or seven (Bryant-Waugh and Lask, 2002). It has been agreed

that early intervention is essential. For example, Thelen *et al.* (1992) recognize that the foundations of an eating disorder are established long before eating disordered behaviours present themselves. If this is the case, then it would seem prudent to address prevention, at the earliest opportunity within a proven 'at risk' group.

## Prevention

The need for prevention programmes addressing eating disorders, has been identified since the early 1980s (Shisslak and Crago, 1994). Fairburn (1995) notes that to date primary prevention programmes have targeted the school-based population. His findings were that a preventative strategy aimed towards the 'at risk' groups would have a more beneficial outcome.

Graber *et al.* (1999) believe that girls would benefit from prevention and early intervention programmes addressing eating behaviours in a developmental context, yet the research literature has revealed a lack of specific interventions targeted at younger children and their mothers. Research has been able to recognize the significant part mothers play in the development of an eating disorder (Evans and Le Grange, 1995; Stein and Woolley, 1996), so it is surprising that this generational argument has not been pursued. It has, as yet, not been adequately identified whether mothers can play an equally significant part in the primary prevention of an eating disorder in the child. Franzen and Gerlinghoff (1997) set up a mother child group to offer therapeutic and educational support to mothers with an eating disorder. They found the mothers became more confident in their parenting role and the group had a positive effect on their symptoms that in turn benefited their children. Stein and Woolley (1996) suggest that the struggle for autonomy can start in the conflict during feeding and mealtimes. They have recommended that sensitive intervention and education may help these mothers become aware of their behaviour, enabling them to implement important change.

## Groups and eating disorders

In a group there is a mutual giving and receiving of information and aid (Bion, 1994). Issues needing to

be confronted in one person are indirectly confronted by the whole group (Stordeur and Stille, 1989; Benson, 2001). Yalom (1985) feels that the participants in the groups should be at various stages of improvement, in order to instil hope of recovery and allow those who have been through certain stages to assist others to understand and integrate their particular difficulties. He also argues that the group should be homogeneous, as the universality of their problem can imbue a sense of validation in the participants and dispel their isolation. Such homogeneity is supported by Butler and Wintram (1995) who believe that feminist group work, namely women's groups run by women, provides scope for re-evaluation with change emerging out of collective and individual action.

An underpinning area of any effective and successful group work is that of cohesion. To ensure such cohesiveness, it is essential that the whole group participates in self-disclosure or 'the affective sharing of one's inner world' (Yalom, 1985). This has a cathartic effect on the individual and leads to an acceptance by the other group members by confirming that other people have been through similar experiences. Yalom (1985) found in several studies that the success of the therapy was directly connected to 'group cohesiveness' and 'general popularity'. McFarland (1995) found that cohesiveness formed more rapidly in a focused group, as everyone is bound by the same purpose and commitment. Running a women's only group allows a safe place for support, shared experiences and is a source of examining different perspectives on similar problems (Butler and Wintram, 1995).

Eating disorders are a secret disorder and can often lead sufferers to feel isolated. The use of a group can help to dispel the notion that they are alone, ensuring awareness that other people suffer from the same problems (Polivy, 1981; Stordeur and Stille, 1989; Protinsky and Marek, 1997). People with eating disorders can be morbidly self-absorbed and have obsessive relationships with food, exercise and body image to the exclusion of most other things. Inclusion within a group can teach them to become altruistic and enable them to recognize that they have the ability and the capacity to help others, thereby providing them with a new counter-solipsistic perspective (Yalom, 1985). Running a group for eating disorders, seemed to facilitate the feeling of being understood without explanation, leading to the acceptance of feedback

and criticism, expediting development (Polivy, 1981).

A structured, time limited group has been argued as a more effective therapy, as it helps reduce the psychological chaos that accompanies eating disorders (Riess, 1992). When the group works well, it can be the most successful form of treatment for eating disorders, offering members increased self-awareness, leading to the ability to recognize and cope with emotions. This in turn leads to lasting change in relationships, increasing the prognosis for lasting recovery (Hall, 1985).

Utilizing such guidance an intervention was designed for this client group. It involved homogeneity of participants, facilitating the effective sharing necessary for cohesion, and ensured the counter-solipsistic paradigm was integrated. It is argued that such a model can be readily transferred to a primary care setting, ensuring this particularly hidden group are able to access effective treatment, thus allowing a more effective use of scarce resources (Thomas *et al.*, 1999).

## Materials and methods

### Design

This research was a qualitative, evaluated, intervention study, without controls, exploring the effectiveness of a semi-structured group in enabling eating disordered mothers to become aware of their potentially damaging behaviour to their children. The aim of the group was to assist the mothers in implementing change in their ability to nurture their own children, in order to prevent the children internalizing behaviour that could be instrumental in the development of their own eating disorder.

### Participants

The participants were mothers with a current or previous diagnosis of anorexia nervosa or bulimia nervosa and with children under the age of 13. 'Jane',<sup>1</sup> had a previous history of both anorexia and bulimia nervosa over a significant period in her past and had been an in-patient in a psychiatric adolescent unit at 16. She considered herself to have ongoing problems regarding food and body image. 'Mandy', had a current diagnosis of anorexia

<sup>1</sup> All names have been changed to ensure anonymity.

nervosa for which she had been receiving treatment for two years and was currently in individual therapy. (Although her therapist was unavailable due to sick leave for the duration of the group.) ‘Penny’, had a past diagnosis of bulimia nervosa, lasting five years and currently described herself as still having issues with food and body image. ‘Jane’ and ‘Penny’ had previously been in individual therapy. All three participants were married and living with their partners.

## Procedure

### The initial interview

Recruited participants were invited to a semi-structured interview before the start of the group. Ethical issues were discussed and permission for the taping of the interviews and the group sessions were sought. Confidentiality was explained and they were asked to sign a consent form for the research and were informed of their right to withdraw their consent without prejudice at any time during the project. A brief personal history was taken, that covered the participants’ own eating behaviour and views regarding their own body image. The interview also investigated the mothers’ behaviour towards their children in five main categories of the ability to nurture. The end interview and both the follow-up interviews were based on the initial interview for the purpose of measuring change.

### The group

The group ran for one and a half hours each week for 11 weeks with a one-week break after four weeks. Each session was semi-structured and focused on the five main themes mentioned below. There was enough space in the sessions for the mothers to discuss their own issues and background, and how those issues linked in to and had a bearing on their behaviour with their children. Each meeting was started by focusing on one of the five categories and then the clients were given the space to explore what these issues meant to them and how they affected their relationship with their children.

### The end, three- and six-month follow-up interview

The end interview took place two weeks after the final session of the group. The format was that of

the initial interview and sought to identify any change in the participants’ eating behaviour and body image and/or any change in their behaviour or views concerning their children, in the relation to the five main areas of the ability to nurture. If the clients felt that there had been any change, whether positive or negative, they were asked if they could attribute that change to the group. The clients were asked their opinion of the group, whether they had enjoyed the group and found it helpful or difficult or problematic. At the three- and six-month interview they were asked if they felt they had been able to maintain any changes in behaviour that had resulted from the group.

### Analysis

The data was analysed thematically using deductive identification (Miles and Huberman, 1994). Five categories of the ability to nurture: food/feeding, body image, modelling, individuation and separation, were identified and were then verified inductively. A final category of the benefits of the group was also inductively identified.

The analysis of the research was able to identify the change in behaviour each participant was able to effect during the lifetime of the group. These changes will be identified below. The three- and six-month follow-up interviews explored if the participants were able to maintain any progress that had been made.

### Separation/individuation

Separation and individuation are fundamental in the aetiology of an eating disorder. If the mother has had difficulties in negotiating these issues for herself, then she is unlikely to be able to encourage her children to become separate individuals. Within the group, work was carried out with the mothers assessing and exploring their feelings and behaviour concerning the control of their children. It was found that all the mothers had certain difficulties in allowing their children to separate and become individuals. This was demonstrated by an inappropriate level of dependency that the mother projected on to the child:

Mandy: I’m more worried about him rejecting me.

Jane: I know it sounds terrible but I don’t want her to grow up.

I suppose I kind of try to attach him to me even more.

(Mandy)

Allowing the child to become an individual and encouraging his independence was very threatening for one of the mothers:

Every step towards independence is saying to me, he does not need me any more, I can go and that's the moment I fear.

(Mandy)

She felt that she would have difficulties in valuing what her child did, if the activity the child undertook was not something that they had shared. Such need for 'control' was similarly demonstrated through the mother's reported difficulties with choice and mess:

On the one hand it's fascinating to see him do it, to see what he is capable of, unless it involves mess, then I stop it.

(Mandy)

As the group progressed, all the mothers were able to comprehend how separation was necessary if the child was to be given the opportunity to develop autonomously. By the end of the group the participants responded to the idea that to give the child space to make their own choices gave them the ability to find out who they were and to develop their own personalities:

Whereas now I'm coming here, I let her make those choices herself, it does work better.

(Jane)

The full findings from the categories of separation and individuation will be given in a forthcoming paper. Nevertheless, these categories would seem to be central to the issue of inter-generational transmission, as analysis within the further three categories found. All contained overt or internal representation of the categories of separation and individuation.

### Food/feeding

At the initial interview and during the beginning phase of the group, issues of control over what the child ate and concern about losing that control, were identified. Feelings of anger about food being

rejected and resentment about having to prepare food were voiced. Mealtimes as a battleground, the inability of the child to sit at the table and eat, the failure of the mother to eat with the child; were common themes.

By the middle of the group Jane, having found that control was an issue, was able to allow her child more choice over food and could tolerate her child taking more control over eating. She felt that being more relaxed about food was enabling her to allow mealtimes to be less of a battleground:

If she says I'm not hungry, I don't go away and cook a meal, come back and put it in front of her and then get all tense because she won't eat it, when she told me in the first place she's not hungry. Before I came here I couldn't understand that.

(Jane)

All the participants were able to look into the way they and their children were using food, for example to gain their mothers' attention, or to keep the child quiet:

I think I've probably used it in the wrong way, when I've been doing something and they've probably wanted my attention, it's 'just have something to eat', just to keep them quiet.

(Penny)

Towards the termination of the group and at the end interview, there was a general consensus that the participants were able to manage their children's food in a more positive way:

Jane: I think I manage [my child's] eating a lot better.

Mandy: I'm more relaxed as far as [my child] goes, his eating behaviour.

They found that they were able to tolerate the rejection of food in a more contained way and not take it as a personal rejection:

If he doesn't want food and he won't have any food, I just bin it.... I would have blamed myself a lot more.

(Mandy)

Mealtimes were reported as being more relaxed and each mother was able to sit at the table with

her children, although one was still unable to eat the same food. The issues of control around food were still recognized and change was being implemented:

I decided I wasn't going to make food a battleground, I didn't want that to be the area of her life that she felt was the only area that she could have any control over.

(Jane)

Taking the control out of food had a positive effect on the feelings of rejection and their levels of anger:

I don't fly off the handle if he rejects food that easily any more.

(Mandy)

Mandy had been able to introduce more cooked food to the child because she had been able to eat some cooked food herself. Penny was slowly trying to introduce more variety into the child's diet and was less anxious about how much her elder child ate. All the mothers were able to identify the fact that if they relaxed more and did not use food to control and battle over, there was a possibility the children would not use food in the same harmful way they had. They understood that using food to assert their authority could be giving out dangerous messages to the child. They began to look for different interventions that were less damaging, such as the use of their time and favourite toys and videos:

Are you hungry or don't you know what to do with yourself? Do you want me to do something with you.

(Penny)

### Modelling

During the initial phase of the group, the mothers began to be aware of how much of their behaviour was mimicked by the children:

Jane: She keeps on and on and on, like I do with her Dad.

Mandy: I find it difficult to interact with other people, but I wish he would build a bit more contacts and friendships, that he would learn social skills with others.

Building on these more general examples, the mothers were able to begin to identify that the way

their children ate was how and what they saw their mothers eat. It was recognized that one child's eating had changed completely. After weaning he ate everything, but at the time of the group he was not eating cooked food. When asked if the mother could find a reason for this she answered:

I assume it was observation on his part, because initially I shared more of the food with him and that's stopped completely.

(Mandy)

It obviously doesn't work by just putting it in front of him. He needs to see me eating.

He's better on the go, than sitting down to eat. That's something I do as well.

(Mandy)

Jane reported reverting to vomiting for a short time during the group and commented that her child:

Gags and tries to make herself sick in the toilet.

(Jane)

Following work in the group, by the mid-point of the intervention, the reality of the ethos 'children learn what they live' was becoming apparent to each of the mothers:

Then I thought, the way she's learned is by watching me and picking up signals from me, that's how she's learned to eat the way she has. So I thought I've got to change the way I approach the issue of food and eating, so that I'm sending out the right messages.

(Jane)

Penny was very concerned about her eldest child as she has reached the same age that the participant was when she started to have the problems that led to an eating disorder. She treats this child differently to the others and worries that she eats too much and does not know when to stop:

Maybe 'cos she's been through being with me in probably more of my difficult times, whether she has picked up something of not knowing when to stop.

(Penny)

Mandy who was unable to eat cooked food, managed to share a cooked meal with her family, which

was an enormous achievement for her at the time. Unfortunately she was not able to maintain this improvement at follow-up. All three participants became aware of the effect that the relationship with their own mother was having on their children. They understood that their behaviour and feelings toward their own mothers was also being imitated by their children.

### Body image

There were several issues relating to body image: the participants view of their own bodies, the view of their children's bodies, and how their own perception of themselves impacted on their children. At the beginning of the group, all the participants had a negative image of their own and their children's bodies. Mandy was concerned about her child becoming too thin, Jane loved the fact that the child was tiny, but still saw a child that was putting on weight:

I didn't want her to get fat, I was always really pleased when I took her to be weighed, that she hadn't put on much weight.

(Jane)

She thinks her child has a 'fat tummy' and tells her so:

I see a child that's putting on weight, who I think could be slimmer.

(Jane)

Penny felt her eldest child was prone to put on weight and was very concerned about it, but tried not to make negative comments:

I don't want her to feel any pressure, because of how I feel about myself.

(Penny)

Jane could not bear her child to see her without any clothes on, as the child made negative comments about her body:

Maybe I say things I don't realise I say, or send out messages that I don't realise I send out.

(Jane)

Mandy realized that her prejudice about being overweight came from her grandmother and her mother. She had introjected that to be overweight represented laziness, embarrassment and that they were not beautiful. Their comments implied:

You have no taste, you have no control, you don't have anything apart from a massive body.

(Mandy)

The recognition that other members of their family had seen their bodies in a negative way, made these mothers realize what an enormous part negative messages had played in the development of their own eating disorder. The wish to bring into awareness the damage that had been and still was being done to them became apparent and they were able to acknowledge the benefits of education regarding behaviour. This in turn led to the realization that their own children will introject their messages:

She'll pick up on me getting hung up on the way that I look. When I realise how much of it comes back to my Mum, it does really worry me about [my child] and any hidden messages that I might send her and by the way I might influence her. I realise just how powerful parental influences have been with me.

(Jane)

By the end of the group the participants were battling to accept their own bodies, but still finding it very hard to do so. Mandy found it difficult because she had gained weight through the group, but she had been able to accept a fairly realistic view of her child's body and felt that he was only slightly slimmer than other children of his age. Penny, was still wishing that her child was slimmer and would watch her weight:

I'm probably unconsciously putting pressure on her there.

(Penny)

### Benefits of the group

The benefits of the group seemed quite considerable. Each participant was able to gain insight into her life and how her behaviour impacted on her

children. One participant had been so influenced by the group that she was able to make a decision to prioritize the mothering role in her life and changed her working hours so that she could spend more time with her child:

I think it gave me the space and the time and the fact that I wanted to reach a balance.  
(Jane)

One comment that was re-iterated was that the group had given them space to explore their issues and that it had been instrumental in awakening their awareness:

Penny: I hadn't realised the subtle ways really in which food was still an issue.  
Mandy: With eating, I think I look at it in a more logical way now.  
Jane: I guess it's given me a head start to be able to think about things.

Such space to think was underpinned through the support and the availability to learn from each other. By recognizing that other people had similar issues, it helped them to normalize their own feelings:

Penny: I mean the support was definitely there within the group, undoubtedly.  
Mandy: I remember her saying that and I know that I try and do that now with [my child]. It has come up in the group that it is difficult to let go, that other mothers find it difficult to let go.

When asked what each participant felt was most beneficial about the group, the answers were as follows:

Jane: It was the input and also listening to some of the things that I said and recognising some of the thought processes that I go through and how some of them are completely nonsensical really.  
Mandy: Listening to others, to their problems, to their experiences but also I guess it's this kind of closeness in a way, being able to talk and also being able to think about it.  
Penny: It was really good to have the opportunity, an hour and a half a week, which you just do not get, to look at certain things.

Participants' expectation of the group had been fulfilled and in some cases they had gained more than had been expected.

Jane: My expectation was that I would be able to handle my relationship with [my child] in a more effective way and I think I'm doing that. I didn't expect to get so much out of it for myself.

Penny: It covered more things for me than I expected it to.

For one participant in particular the group had brought awareness that her child could develop an eating disorder. This had created a great deal of anxiety, as at that stage she felt it was going to be difficult to maintain any significant change in her behaviour.

Because the key lies with me, because I can't change my own behaviour. I think if anything it probably has strengthened my anxiety, because beforehand I didn't realise that he could be influenced by my behaviour. So it's made me aware of my indirect power.

(Mandy)

## Discussion

The use of a group was instrumental in identifying the pervasive damage that mothers with an eating disorder can unwittingly do to their children. It strongly indicated that a group was an effective method to support and encourage change (Levine and Piran, 2001). The field of prevention shares an assumption that knowledge and behavioural skills result in change (Vandereycken and Noordenbos, 1998). Although the sample was small, the results identified that all three participants were able to benefit from the use of the group. This was encouraging enough to support plans for a larger study.

The study revealed that the group was able to heighten behavioural awareness for these mothers. They were able to link their behaviour to possible damage that might occur to their child. Within the safety of the group, they were able to acknowledge how their behaviour was impinging on their children. Each participant agreed that knowledge and understanding played an integral part in instigating



a desire to work on ways to change. While actively focusing on the mother–child relationship, the benefits spilled over and enable the mothers to examine their own issues, with the resulting advantage of reducing the damage to both mother and child. Having a forum to examine their behaviour, they were able to evaluate the damaging effects their own maternal influences had, this led them to a determination ‘to do things differently’ for their children and a belief that the mould could be broken.

This pilot study has indicated the benefits of forming a group to support these mothers in being able to nurture their own children more effectively. It points to the need for further research in this area on a larger scale and it is hoped that further groups can be established with a view to contributing to the primary prevention of eating disorders in future generations.

### Recommendations

At present prevention programmes exist as school-based programmes. There have been extremely limited trials that involve mothers and young children. One of the aims of this research is to develop a protocol for running the group, which can be disseminated to Primary Care Organizations (PCOs). The development of interventions that encourage social adjustment, improve coping strategies and implement prevention would seem to be a prudent resource (Corney and Jenkins, 1995). Primary care professionals are the main point of contact for people seeking help with an eating disorder. District nurses, midwives and health visitors who support new mothers are in the best position to identify mothers with an eating disorder who might have children at risk and counselling services are now widely available in primary care. If PCOs throughout the UK are in a position to run a group then the possibility for wide spread prevention is considerable. The National Health Service Framework for Mental Health (Department of Health, 1999) targeted programmes that enable patients with mental health problems to access services in primary care. Gournay (2002) believes that only a small number of mental health patients receive the appropriate treatment and recommends that the primary health care teams are an obvious group for training attention.

When eating disorders become embedded and chronic, treatment becomes a very lengthy and expensive process, often resulting in repeated hospitalization. If these disorders can be prevented or lessened in any way then we are not only helping the individual but are also lessening the financial burden on the health service.

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