

The source of this intolerance is widespread, ranging from family, peers, friends, the online community, the medical profession and policy makers. For example, public health interventions targeting obesity may harm through weight stigmatization and increasing body dissatisfaction⁵. Indeed, data from three ongoing birth cohorts in the UK suggest that weight control behaviours have increased in adolescents of both genders (almost 50% report dieting), which may produce a steep increase in eating disorders within the next decade⁶.

The implications drawn from the epidemiology of disordered eating and the emerging genetic associations suggest that complex interactions between the environment and somatic and psychological factors are causally involved in the development of eating disorders. A wide range of variables can moderate the expression of these vulnerabilities. A broader approach to the prevention of both eating disorders and obesity is needed, with a central focus on reducing weight stigma and increasing healthy forms of eating and exercise behaviours rather than promoting unhealthy patterns of food restriction. Eating disorders affect individuals of all body weights, shapes and sizes, and it is of concern that heavier patients may not be considered “ill enough” either by themselves or by the gatekeepers of financially constrained eating disorder services, thus missing the opportunity for early intervention.

At the other end of the care pathway, new approaches are being developed for people with eating disorders who have failed to respond to standard treatment. Advances in the management of binge eating disorder include treatments targeting psychological processes believed to precede and perpetuate the disorder, such as reward sensitivity, inhibitory control, ADHD tendencies and interoceptive awareness. One example is represented by strategies that focus on increasing inhibitory effortful control⁷.

Mental health of children and parents after very preterm birth

Having a baby at less than 32 weeks gestation is a highly stressful and potentially traumatizing experience for parents. For almost all parents, there is heightened anxiety about their baby's health and well-being. In some cases, the birth itself may be traumatic, and women may require an intensive care admission and/or longer stay in hospital. Parents may be separated from their baby for extended periods of time unless there is provision for them to stay alongside their baby in the neonatal intensive care unit.

As well as the immediate risks to their baby's health, parents are faced with uncertainty about their baby's longer-term health and development. There is increasing recognition that children born very preterm (<32 weeks gestation) are vulnerable to mental health difficulties in childhood and adolescence¹. In the preschool period, they are more likely to experience internalizing and dysregulation difficulties compared with term-born peers². There is also evidence of an increased risk for symptoms and diagnoses of attention-deficit/hyperactivity disorder (ADHD) in the preschool period for children born extremely preterm (<28 weeks gestation)¹. By school age, compared with term-born chil-

In severe anorexia nervosa, there are intriguing case reports describing the use of metreleptin, a recombinant human leptin analogue often used to treat excess appetite in people with lipodystrophies. The seemingly counterintuitive rationale for this is based on experimental work derived from activity-based animal models of anorexia nervosa⁸. Metreleptin led to an immediate reduction in depression, and a later resolution in eating disorder behaviours⁹. A similar profile of change has been seen following neuromodulatory techniques.

Thinking forward, advances in our understanding of the evolving epidemiology and differential etiopathogenetic factors associated with eating disorders can improve prevention and treatment, and hopefully reduce the incidence of these conditions.

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DOI:10.1002/wps.20935

dren, children born very preterm have three times higher odds of meeting criteria for any psychiatric disorder³.

The pattern of mental health difficulties and psychiatric diagnoses in children born very preterm appears to be clustered around the key areas of attention, social and emotional difficulties. This is reflected in increased rates of autism spectrum disorder (ASD) and ADHD diagnoses by school age for those born very or extremely preterm^{1,3}. This pattern continues into early adolescence, with the most prevalent diagnostic categories for those born preterm being ADHD, ASD and anxiety disorders⁴. Over time, the risk for psychiatric disorder associated with preterm birth appears to decrease, although some studies report ongoing differences in mental health outcomes⁵, with implications for quality of life and functioning.

Mothers and fathers of infants born very preterm experience elevated levels of depressive, anxiety and post-traumatic stress symptoms compared with parents of term-born babies. One study found that approximately 40% of mothers and fathers experienced depressive symptoms and almost 50% reported anxiety symptoms

soon after the birth⁶. Another showed that approximately one third of mothers and fathers experienced post-traumatic stress symptoms in the early months after very preterm birth, with almost one fifth of parents continuing to report post-traumatic stress symptoms two years after the birth⁷. Symptoms of depression and anxiety in parents of babies born preterm also appear to remain higher across childhood and adolescence compared with parents of term-born babies.

For those born very preterm, early social-emotional difficulties have been associated with later mental health symptoms and diagnoses^{1,3}. Factors such as higher socioeconomic risk early in life and severe neonatal brain abnormalities have also been associated with increased risk for later mental health difficulties in these children³.

Currently, less is known about factors that increase the risk for parental mental health problems after preterm birth. Some studies suggest that social disadvantage increases the risk for poor maternal mental health, while others have not shown an association. Parental history of mental health difficulties may be an important factor to consider, but has rarely been studied in this population.

Given the complexity of predicting which babies and which parents might be at greatest risk for mental health difficulties after very preterm birth, it is important to remember that experiencing preterm birth is in itself a risk factor for mental health difficulties. Knowing this, we need a systematic and integrated response to promote well-being, monitor mental health, and facilitate access to evidence-based early intervention for *all* families who experience very preterm birth. Parents and babies are often in the hospital for several months, meaning that there are opportunities to implement screening and support programs within the hospital, and connect families with external services which can continue to provide monitoring and intervention where needed across early childhood and into adolescence for both children and parents. In development of such systems, it is important to keep in mind that rates of mental health difficulties after preterm birth are similar in mothers and fathers^{6,7}.

Intervention after preterm birth should be responsive, individualized and multi-layered, and include direct psychological support for parents and broader early intervention programs to enhance infant development and the parent-child relationship. For example, individualized parent trauma-informed psychological interventions in the neonatal intensive care unit, and broad early intervention programs for families after preterm birth have been associated with better parental mental health⁸. There is also evidence that early intervention for families after preterm birth

can improve child emotional regulation and behaviour⁹. Longer-term effects of early intervention on school-age and adolescent mental health are unknown, and support should be guided by current evidence-based practice in child and adolescent mental health intervention.

Health professionals working with children and parents after preterm birth should be aware of the increased rates of depression, anxiety and post-traumatic stress symptoms in parents, and the elevated risk for ADHD, ASD and anxiety symptoms and disorders in children and adolescents. In the early years after preterm birth, medical and allied health professionals who see families for routine post-discharge assessment or are working with families in early intervention services are well-placed to continue or initiate conversations around mental health and well-being with parents and provide information and referrals to mental health professionals when needed.

For mental health professionals working with paediatric clients, asking parents about whether the child was born preterm and subsequent history of physical and mental health and development would not only provide important information about the child, but also potentially open discussion around the experience of the parents. Mental health professionals working with parents after preterm birth should be mindful of its potential long-term impact on parental mental health and the risk for ongoing post-traumatic stress symptoms, that may present in both mothers and fathers.

Overall, the available evidence suggests that the individual as well as the couple and/or family experience of very preterm birth is an important under-recognized issue.

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DOI:10.1002/wps.20936

How clinicians can support women in making decisions about psychopharmacological treatments in pregnancy

Ensuring that women can make fully informed decisions about all aspects of their care in pregnancy is not only required by law in many jurisdictions, but is integral to the provision of respectful and contemporary person-centred health care.

Many health systems acknowledge now the importance of mental health in pregnancy through the common practice of universal screening for depression, as well as the increased awareness and health promotion campaigns around maternal mental