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CASE REPORTS

Feeding difficulties in the offspring of mothers with an eating disorder - a case report

Dificuldades alimentares em filhos de mães com perturbações do comportamento alimentar – um caso clínico

Pedro Carvalho e Marques[1], Teresa Sá[1], Vânia Martins[1]

ABSTRACT

Background: One of the main risk factors for eating disorders (ED) in early childhood is maternal ED. Mothers with a history of ED have difficulties in their approach to feeding their children, with mealtimes being perceived as stressful, with controlling behavior and intrusiveness.

Case presentation: An 11-month-old female infant was evaluated at a Child Psychiatry Consultation for feeding difficulties. Her mother had a history of Restrictive Anorexia Nervosa. Mother-child psychotherapy was performed due to a pattern of insecure attachment and an ongoing conflict over control and autonomy between the caregiver-child. After the intervention, mealtimes became more natural and less conflictual.

Discussion and conclusion: The authors aim to shed light on the transgenerational transmission of ED. Feeding interactions between mothers with ED and their offspring are less harmonious, with greater conflict, controlling behaviors, negative affect and decreased emotional availability to the child. Clinicians must be aware of a potential parental history of ED when dealing with children with feeding problems.

Keywords: anorexia nervosa; childhood eating and feeding disorders; eating disorders; parent child interaction

RESUMO

Introdução: Um dos principais fatores de risco para as perturbações do comportamento alimentar (PCA) na infância são as PCA maternas. Mães com histórico de PCA apresentam dificuldades ao alimentar os seus filhos, sendo as refeições percebidas como disruptivas, observando-se comportamentos controladores e intrusivos.

Apresentação do caso: Uma criança do sexo feminino, com 11 meses, foi avaliada numa Consulta de Psiquiatria Infantil devido a dificuldades alimentares. A mãe tinha antecedentes de Anorexia Nervosa Restritiva. Foi realizada psicoterapia mãe-criança devido a existência de um padrão de vinculação inseguro e um conflito contínuo sobre controlo e autonomia entre a cuidadora e criança. Após a intervenção, as refeições tornaram-se mais naturais e menos conflituosas.

Discussão e conclusão: Os autores pretendem destacar a transmissão transgeracional de PCA. As interações alimentares entre mães com PCA e os seus filhos são menos harmoniosas, com maior conflito, comportamentos controladores, afeto negativo e diminuição da disponibilidade afetiva para a criança. Os profissionais de saúde devem estar cientes de um possível histórico de PCA nos pais ao observar crianças com dificuldades alimentares.

Palavras-chave: anorexia nervosa; interação cuidador-criança; perturbações do comportamento alimentar

1. Department of Child and Adolescent Psychiatry, Centro Materno-Infantil do Norte, Unidade Local de Saúde de Santo António. 4050-651 Porto, Portugal. pnunomarques@gmail.com; teresasa.pedopsiquiatria@chporto.min-saude.pt; vaniamartins.pedopsiquiatria@chporto.min-saude.pt

BACKGROUND

Feeding and eating difficulties are commonly reported problems by parents in a Child Psychiatry consultation.[1,2] Nurturing the infant is a pivotal responsibility in parenting, not only due to its time-consuming nature during the early stages of life but also because it serves as a significant form of communication between the mother and child.[3] An adequate feeding requires a coordinated play between the child's own characteristics, the behaviors of the caregiver during mealtimes and the relationship between the child and the caregiver.[1,4,5] When parents struggle with their children's feeding, it challenges their ability to ensure survival and a healthy development of their children. A troubled relationship between the child and the caregiver is one of the main causes of feeding difficulties in early childhood.[1,4,6] Disturbed patterns of interaction between mother and child have been described in cases of feeding and eating disorders by Chatoor and colleagues as early as the 1980s decade.[6]

Strong evidence suggests that offspring of parents with psychiatric disorders are at a higher risk of developing psychopathology.[3] One of the main risk factors for eating disorders (ED) in early childhood is a maternal history of psychiatric disorders, mainly ED.[1,4,5,7,10]

The association between parental eating disorders and children's feeding difficulties is still to be clarified but it is believed that it can be influenced by genetic factors, the infant's temperament, parental psychopathology and parental past experiences.[7,9] In addition to the strong genetic component, ED may be transmitted from parents to their offspring through indirect effects of ED symptomatology on general parenting functioning such as preoccupation with food and weight, and direct effects that involve influencing the dietary choices parents make.[10] A strong mediator for ED in offspring of mothers with ED is maternal distress, such as depression and anxiety, which worsens mother-child bonding.[5,10]

Mothers with a history of ED often have difficulties in their approach to feeding their children, with mealtimes being perceived as a stressful and conflictual control moments.[3,7] This leads to less dyadic reciprocity, feelings of guilt, maternal perception of a difficult temperament of the infant, more negative affect and more restrictive and controlled mealtimes.[7,11] Moreover, they often express feelings of inadequacy and a sense of being incapable in their role as parents.[10]

Mothers with ED have specific parenting styles that can lead to feeding difficulties in their offspring.[3] They are characterized by a strong controlling behavior (during play and mealtimes), intrusiveness during mealtimes and more expression of negative emotions.[5] Mealtimes usually have a slow and monotonous pattern and there is a lack of consistency in feeding routines and in setting boundaries.[3,5,7] Therefore, children often exhibit dysregulated behaviors during mealtimes, with refusal to eat as a form of communicating discomfort.[7]

Children of mothers with ED are more likely to have adverse developmental outcomes, including more emotional and behavioral problems, cognitive difficulties, difficult temperament, neurobehavioural dysregulation early after birth and poorer language and motor development.[3,10,12]

Based on a case report of an infant with feeding difficulties followed in a Child Psychiatry service, whose mother had a history of Anorexia Nervosa, the authors aim to shed light on the transgenerational transmission of ED and on the expected feeding difficulties in children of mothers with ED.

CASE PRESENTATION

L., a female infant aged 11 months, was evaluated at a Child Psychiatry Consultation, accompanied by her mother, because of feeding difficulties and refusal to eat with her parents. She was an only child, with no relevant history of medical conditions. She had already been evaluated by Pediatrics, which excluded an organic etiology of the feeding difficulties. There was no weight loss or failure to thrive. The mother was 30 years old, with a medical history of Restrictive Anorexia Nervosa and Depression at 20 years old. The father was 30 years old, with no history of medical or psychiatric problems.

The mother mentioned feeding difficulties since birth, because L. refused and cried while she was being breastfed. The feeding difficulties worsened with the beginning of food introduction at 4 months, with behaviors of food refusal exclusively when fed by the parents. She showed no difficulties when eating on her own. The parents force fed the baby during nighttime while she was asleep, afraid that she would lose weight. The prolonged mealtimes were perceived as stressful and chaotic. The mother described the infant as "serious, silent and independent" *(sic)* and played mostly by herself. She would frequently avoid eye contact with her parents. She also occasionally demonstrated aggressive behaviors towards the parents, inconsolable crying and initial insomnia. The parents showed insight into their child's feeding difficulties and its relation to the child's emotional needs not being consistently met, referring that "we ended up not respecting what she wanted" *(sic)* and that "we are afraid she won't trust us again" *(sic)*.

During the first consultation, the infant presented a serious facial expression, looking and smiling mainly towards the doctors and rarely towards the mother. The child would walk away from the mother, exploring the surroundings with curiosity and pleasure. The infant-mother interaction was very silent, characterized by a lack of reciprocity and synchronicity. The mother presented difficulties in joining the child's play and reading her clues. During the interaction with her daughter, she stood still and did not follow the child's cues. We performed an adaptation of Mary Ainsworth's Strange Situation which revealed an insecure avoidant attachment with the mother. In a second appointment, we performed the same adaptation of the Strange Situation with the father, but this time the pattern was of a secure attachment.

A developmental assessment was performed using the Griffiths Mental Development Scale with an above average general development quotient (143).

According to the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5)[2], in Axis I (Clinical Disorders), there was a diagnosis of Undereating Disorder. In Axis II (Relational Context), we classified the caregiver-infant relationship as level 3 of adaptation – a compromised to disturbed relationship – and the caregiving environment and infant adaptation was classified as a level 2 – a strained to concerning caregiving environment. There was no diagnosis on Axis III (Physical Health Conditions and Considerations). In Axis IV (Psychosocial Stressors), there was maternal mental health problems (history of Restrictive Anorexia Nervosa and Depression). In Axis V (Developmental Competence), the infant exceeded developmental expectations.

Regarding intervention, we started mother-child psychotherapy, which aimed to promote reflective thinking and insight about feeding difficulties as a relational problem of the dyad. There was an ongoing conflict about control and autonomy between the caregiver-child and the main focus was to improve this dyadic relationship, as there was also a pattern of insecure attachment. During this process, the mother was able to express her feelings of guilt about being too intrusive and controlling during mealtimes, often remembering her past restrictive anorexia nervosa diagnosis. The mother felt like she was reliving her trauma, stating she did not want her daughter to go through the same thing as she did and become excessively worried about food. During the sessions, the mother became progressively involved in the relationship and play with her daughter, and mealtimes became increasingly more natural and less conflictual. The infant started to smile more and became more talkative and interactive with her mother during playtime. The child began accepting parent-led feeding, although she still preferred eating by herself. The aggressive behaviors and sleep difficulties stopped. The infant initiated daycare at 17 months, with good adaptation and interaction with peers. No feeding difficulties were reported in daycare.

After six months of intervention, we repeated the adaptation of Mary Ainsworth's Strange Situation Procedure with the mother, which showed a pattern of secure attachment (opposite to the initial insecure attachment pattern). The parents reported no complaints about feeding, stating it was no longer a problem for the family. They started to promote more autonomy during mealtimes, while being less intrusive and controlling. During interaction with her caregivers, the infant showed more pleasure and reciprocity in the relationship.

DISCUSSION AND CONCLUSION

Maternal ED is a well-known risk factor for feeding problems in children.[5,8,10,13,14] Magnusson *et al*. described rates of eating disorders as twofold higher in the offspring of parents with a diagnosed ED and a strong association between ED in mothers and female children.[14]

We believe our case report clearly illustrates this intricate association between a maternal history of Anorexia Nervosa and an eating disorder in early childhood. In this case, there was a disturbed pattern of interaction between mother and child, during play and, specially, during mealtimes, which were characterized by marked intrusiveness and control by the mother. In their work, Patel *et al* highlight that mothers with ED are more likely to be intrusive at mealtimes, use food for non-nutritive purposes, and express negative comments and affect towards their children at mealtimes.[8]

Negative parental mealtime management, often seen in mothers with ED, is a strong predictor of feeding problems, particularly of food refusal in children.[9] During mealtimes, there is an increasing conflict over autonomy and control between the parent and the infant, exacerbated by the development of separation and individuation process.[6] In cases of feeding disorders, there are usually inconsistent and non-contingent responses from the caregivers who fail to read the infant's signals. They are prone to more negative affect, leading to dyadic conflict and constant struggle for control, which inevitably results in intrusive and forced feeding.[6] In our case, the caregiver-child relationship was characterized by an ongoing conflict regarding control and autonomy.

In fact, studies show that feeding interactions between mothers with ED and their offspring are less harmonious, and are marked by greater conflict, extensive controlling behaviors, negative affect during mealtimes, decreased emotional availability to the child, when compared to mothers with no history of ED.[13] Mothers with lifetime eating disorders and their toddlers display less adaptive emotional responsiveness to one another, therefore they are at risk of having more communication and attachment difficulties.[13]

The presence of a maternal ED can negatively impact children's temperament and mothers with ED often perceive their child as having a difficult temperament.[15] There could be a link between maternal ED and infant negative emotional responses, with comorbid maternal depression as a possible factor.[10] Mothers with ED often present difficulties in recognizing their child's clues, namely differentiating between hunger and satiety states, with food often being used for non-nutritive purposes.[7] This impaired sensitivity towards the child's needs affects the dyadic relationship. Besides, the mother's cognitive misbeliefs about her condition, self-image and eating usually have a direct impact on how the relationship with her child and her feeding is perceived.[7]

The mother's distorted beliefs about eating, body shape and weight could influence her caregiving approach, leading to changes in her responsiveness to the child's needs and reactions. This ultimately affects the quality of their relationship.[7]

A study by Micali *et al* investigated the effect of maternal ED on mother-infant quality of interaction at 8 weeks and bonding and child temperament at one and two years old. Although there were no differences between early mother-infant interaction and bonding

in mothers with ED in comparison to the control group, they found that high levels of maternal ED psychopathology were correlated with high anxiety, higher negative affectivity and lower extraversion in children of ED mothers both at one and two years.[10]

In our case, we diagnosed an Undereating Disorder in Axis I. One of our differential diagnosis was Relationship Specific Disorder of Infancy/Early Childhood. However, this diagnosis can only be made if the infant exhibits a persistent emotional or behavioral disturbance, such as food refusal, in the context of one particular relationship with a caregiver.[2] As the infant in our case presented feeding difficulties with both caregivers, this diagnosis was ruled out. However, the relational component of these difficulties cannot be overlooked and must be a target of psychotherapeutic intervention. Even though the feeding problems were present with both caregivers, we prioritized a child-parent psychotherapy (CPP) focused on the mother-child dyad because the child exhibited a pattern of secure attachment to her father and an insecure attachment to her mother, with a concerning lack of tuning and reciprocity in their interaction. In the end, this proved beneficial for both the dyadic mother-child relationship and addressing the feeding problems.

CPP is a relationship-based treatment which addresses mental health issues or potential disturbances in infants, toddlers, and preschoolers. The primary aim is to assist parents in establishing both physical and emotional security for the child and the family. This is achieved through joint child-parent sessions where the therapist interprets the child's behavior for the parent (using spontaneous behavior, play and interactions) and aids the child's understanding of the parent's intentions.[1]

When feeding problems reflects a significant relationship disorder, the focus of treatment needs to be the relationship and not necessarily the feeding. In cases where parents have their own history of eating disorders, the therapist must allow them to understand how their past experiences, fears and mental health issues can affect their parenting and disrupt their capacity to observe, understand, and address the child's needs.[1,4] CPP helps to connect the parents' previous distressing experiences with their present functioning, their view of the child, and how they approach parenting.[1] Parents with history of eating disorders have their own issues about trust, autonomy, and control which impacts parents' perception of their children's need.[1,4] The therapist must help parents understand the developmental conflict of their infant around autonomy and dependency and expression of this conflict through food refusal.

Parental eating disorders can impair the infant's cognitive, psycho affective and social development. However, there is still limited knowledge regarding the interplay of genetic and environmental factors and how they influence this risk.[3,7] It is therefore necessary to study reciprocal influence between mother's eating disorders and infants' feeding behaviour.[7] Gaining a deeper comprehension of how maternal eating disorders impact child development can aid in recognizing elements of both vulnerability and strength that can be focused on, for effective therapeutic and preventive approaches. This is especially relevant to identify modifiable pathways of risk, thus leading to more tailored interventions.[10]

With this case, the authors aim to alert clinicians for a potential parental history of ED when dealing with children with feeding problems. An early psychotherapeutic intervention in the dyadic relationship is necessary to facilitate caregiver-infant interaction and to improve their relationship and feeding pattern.[10]

AUTHORSHIP

Pedro Carvalho e Marques – Conceptualization; Writing - original draft; Writing - review & editing

Teresa Sá - Writing - review & editing

Vânia Martins - Writing - review & editing; Supervision

REFERENCES

1. Zeanah CH Jr. Chapter 23: Eating and Feeding Disorders in Early childhood. In: The Guilford Press. *Handbook of Infant Mental Health*, Fourth Edition. The Guilford Press; 2018.p392-406.
2. Zero to Three. DC:0–5™: Diagnostic classification of mental health and developmental disorders of infancy and early childhood. Washington, DC. 2016.p.99-109.
3. Martini MG, Barona-Martinez M, Micali N. Eating disorders mothers and their children: a systematic review of the literature. Arch Womens Ment Health. 2020 Aug;23(4):449-467. doi: https://doi.org/10.1007/s00737-020-01019-x.
4. Chatoor I. Feeding disorders in infants and toddlers: diagnosis and treatment. Child Adolesc Psychiatr Clin N Am. 2002 Apr;11(2):163-83. doi: https://doi.org/10.1016/s1056-4993(01)00002-5.
5. Micali N, Simonoff E, Stahl D, Treasure J. Maternal eating disorders and infant feeding difficulties: maternal and child mediators in a longitudinal general population study. J Child Psychol Psychiatry. 2011 Jul;52(7):800-7. doi: https://doi.org/10.1111/j.1469-7610.2010.02341.x.
6. Chatoor I, Egan J, Getson P, Menvielle E, O'Donnell R. Mother-infant interactions in infantile anorexia nervosa. J Am Acad Child Adolesc Psychiatry. 1988 Sep;27(5):535-40. doi: https://doi.org/10.1097/00004583-198809000-00003.
7. Squires C, Lalanne C, Murday N, Simoglou V, Vaivre-Douret L. The influence of eating disorders on mothers' sensitivity and adaptation during feeding: a longitudinal observational study. BMC Pregnancy Childbirth. 2014 Aug 14;14:274. doi: https://doi.org/10.1186/1471-2393-14-274.
8. Patel P, Wheatcroft R, Park RJ, Stein A. The children of mothers with eating disorders. Clin Child Fam Psychol Rev. 2002 Mar;5(1):1-19. doi: https://doi.org/10.1023/a:1014524207660.
9. Coulthard H, Blissett J, Harris G. The relationship between

parental eating problems and children's feeding behavior: a selective review of the literature. Eat Behav. 2004 May;5(2):103-15. doi: https://doi.org/10.1016/j.eatbeh.2003.07.003.

10. Martini MG, Taborelli E, Easter A, Bye A, Eisler I, Schmidt U, Micali N. Effect of maternal eating disorders on mother-infant quality of interaction, bonding and child temperament: A longitudinal study. Eur Eat Disord Rev. 2023 Mar;31(2):335-348. doi: https://doi.org/10.1002/erv.2960. Epub 2022 Dec 5.
11. Park RJ, Senior R, Stein A. The offspring of mothers with eating disorders. Eur Child Adolesc Psychiatry. 2003;12 Suppl 1:I110-19. doi: https://doi.org/10.1007/s00787-003-1114-8.
12. Micali N, De Stavola B, Ploubidis GB, Simonoff E, Treasure J. The effects of maternal eating disorders on offspring childhood and early adolescent psychiatric disorders. Int J Eat Disord. 2014 May;47(4):385-93. doi: https://doi.org/10.1002/eat.22216.
13. Sadeh-Sharvit S, Levy-Shiff R, Arnow KD, Lock JD. The interactions of mothers with eating disorders with their toddlers: identifying broader risk factors. Attach Hum Dev. 2016 Aug;18(4):418-28. doi: https://doi.org/10.1080/14616734.2016.1164201.
14. Bould H, Sovio U, Koupil I, Dalman C, Micali N, Lewis G, Magnusson C. Do eating disorders in parents predict eating disorders in children? Evidence from a Swedish cohort. Acta Psychiatr Scand. 2015 Jul;132(1):51-9. doi: https://doi.org/10.1111/acps.12389.
15. Micali N, Stahl D, Treasure J, Simonoff E. Childhood psychopathology in children of women with eating disorders: understanding risk mechanisms. J Child Psychol Psychiatry. 2014;55(2):124-34. doi: https://doi.org/10.1111/jcpp.12112. Epub 2013 Jun 27.

CORRESPONDENCE TO

Pedro Carvalho e Marques
Department of Child and Adolescent Psychiatry
Centro Materno-Infantil do Norte
Unidade Local de Saúde de Santo António
Largo da Maternidade de Júlio Dinis 17
4050-651 Porto
Email: pnunomarques@gmail.com

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