Child feeding perceptions among mothers with eating disorders

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Abstract
Feeding and eating difficulties are documented among the offspring of mothers with eating disorders. Understanding the perspective of mothers with eating disorders is likely essential to develop parent-based early prevention programs for children of these mothers. In the present study, twenty-nine mothers who were diagnosed with an eating disorder prior to becoming mothers and who currently had toddler age children participated in a semi-structured interview examining maternal functioning and child feeding. The maternal perceptions that emerged from the interviews were sorted into central themes and subcategories using interpretive phenomenological analysis. Data indicate that mothers with eating disorders express preoccupation with their child's eating, shape and weight, and many dilemmas about child feeding. They also reported rarity of family meals and their toddlers' preliminary awareness of maternal symptoms. Maternal concerns regarding child nutrition, feeding and weight were reported as more intense in regards to daughters. These maternal perceptions illuminate the maternal psychological processes that underlie the feeding and eating problems of the children of mothers with lifetime eating disorders. Findings should be addressed in the evaluation, treatment, and research of adult and childhood eating disorders.

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1. Introduction
The offspring of mothers with eating disorders are at an increased risk for feeding and eating problems as well as other developmental, behavioral and emotional difficulties (Agras, Hammer, & McNicholas, 1999; Micali, 2005; Zerwas et al., 2012). In particular, the development of healthy eating habits appears to be significantly compromised for these children. As early as six months of age, the children of mothers with Anorexia Nervosa are more likely to experience feeding problems, and their mothers report greater child emotional eating at age four years (de Barse et al.). The children of mothers with Bulimia Nervosa are more likely to be overweight and have difficulty transitioning to solid foods compared to children of mothers without an eating disorder (Agras et al., 1999). Additionally, infants of mothers with lifetime eating disorders exhibit less positive affect with their mothers during feeding and play (Stein, Woolley, Cooper, & Fairburn, 1994). Elementary-school children whose mothers have lifetime eating disorders are more likely to have “health-conscious” eating habits (Ammaniti, Lucarelli, Cimino, D’Olimpio, & Chatoo, 2012; Easter et al., 2013; Micali, Simonoff, Stahl, & Treasure, 2011), and by age thirteen they report greater disordered eating and emotional eating as compared to children whose mothers do not have histories of eating disorders (Allen, Gibson, McLean, Davis, & Byrne, 2014).

These early years are critical in shaping children’s eating habits (Danaer, Fredericks, Bryson, Agras, & Ritchie, 2011) and mothers are most commonly in charge of determining their children’s daily feeding routines. Mothers usually decide what foods are offered, the amount that is provided, the timing and context of meals, and who is involved in feeding interactions (Rapoport & Bourdais, 2008). Most studies suggest that these feeding-related decisions
are more complicated and distressing when the mother has a history of an eating disorder (Mazzeo, Zucker, Gerke, Mitchell, & Bulik, 2005). For example, in comparison to control mothers, mothers with a history of an eating disorder are more preoccupied with their child’s weight and underfeed their children (Hodes, Timimi, & Robinson, 1997; Hoffman et al., 2012). Maternal co-occurring obsessive-compulsive symptoms mediate the links between the maternal eating disorder and her restrictive feeding practices (Farrow & Blissott, 2009). At the same time, though, these mothers also use food more frequently than other mothers for non-nutritional purposes, such as soothing or distracting the child (Agras et al., 1999; Evans & Le Grange, 1995). Analyses of recorded feeding interactions between mothers with eating disorders and their children generally revealed increased conflicts, stricter control over the child’s eating, and more maternal negative emotions in comparison to non-symptomatic dyads in several studies (Haycraft & Blissott, 2010; Park, Senior, & Stein, 2003). However, a recent study that assessed mothers who recovered of their eating disorder did not find differences (Hoffman et al., 2013).

Evidence suggests that certain aspects of the maternal eating disorder likely play a different role in different developmental stages. For example, the more severe the mother’s eating disorder, the more controlling her feeding practices are with her infant (Stein et al., 2001). For elementary and middle school children these mothers showed greater concerns for the child’s weight and were correlated with children’s report of their own eating disorder symptoms (Allen et al., 2014). These findings imply that older children’s autonomous eating may be mediated by maternal perceptions. As a field, our knowledge of how to help these mothers and their children is limited and there is little data on evidence based treatments for this population. Given that psychological treatments of eating disorders rely heavily on words, understanding the language that mothers with lifetime eating disorders use to talk about their concerns, dilemmas, and practices in feeding their children is essential for gaining a better understanding of their behaviors as well as designing and refining any intervention programs.

To shed further light on the role of maternal eating disorders in childhood feeding, eating, and development, the current study uses focused interviews to explore maternal feeding-related perceptions in mothers with eating disorders with toddler age children. While this is a qualitative study, we predicted that concerns regarding their children’s eating behavior and appearance would be similar to those found in adults with eating disorders in regards to themselves, including attitudes, beliefs and practices around restricted food consumption and a great emphasis of the thin ideal.

2. Methods

2.1. Participants

Twenty nine mothers with a prenatal eating disorder diagnosis who had a toddler between 18 and 42 months old were interviewed in the current study. Participants were recruited from three psychiatric centers in Israel, specializing in the treatment of eating disorder. Participants were included in the study if they had been diagnosed by an experienced mental health professional with either Anorexia Nervosa (N = 14), Bulimia Nervosa (N = 13), or Eating Disorder Not Otherwise Specified (N = 2), based on DSM-IV criteria (APA, 2000), and if their child’s age was between 18 and 42 months at the time of the study.

The average age of the mothers was 31 (SD = 4.2), and the children ranged in age from 18 to 42 months, with an average age of 32.5 (SD = 7.2) months. Sixty six percent of the children were girls and forty five percent were first-born. The average onset age of the maternal eating disorder, according to maternal report, was fourteen (range: 6–20 years old). In regards to the presence of current symptoms among the mothers, twenty seven (93%) reported at least one of the following symptoms in the week preceding the researcher’s visit: binge eating (52%), food restriction (41%), and/or compensatory behaviors, such as purging or using diuretics (48%). At the time of data collection seventeen mothers received outpatient treatment for their eating disorder and none were hospitalized.

2.2. Semi-structured interview

Each mother participated in a semi-structured interview developed by the first author. This interview was based on the literature of mothers with eating disorders and aimed to elucidate the ways by which mothers find solutions for their feeding-related concerns and dilemmas. The interview aimed at exploring the mother’s view of the effects of her eating disorder on maternal functioning and child feeding, through mostly open ended interview questions. Pilot interviews were delivered to ten percent of the sample (four participants), and the themes that emerged inspired the elaboration of further prompts (see Fig. 1). Each interview lasted approximately 60 min, and was conducted at the participant’s home. All interviews were audio-recorded and later transcribed verbatim to minimize loss of data.

2.3. Procedure

Following the Institutional Research Board approval from each center, we identified in the centers’ records 108 current or past patients who were thought to be married or have children. Of these, ten had a child younger than 18 months, and thirty eight were mothers of children older than 42 months (which were below or above the child cutoff age eligible to partake in the study, respectively). Nineteen patients were not tracked down, and an additional mother was excluded since her child was born in the second trimester and this could have affected child feeding patterns. Out of the remaining forty eligible mothers, 29 (72.5%) consented and were interviewed.

2.4. Qualitative data analysis

Interpretation of the interviews was performed by the first author using interpretive phenomenological analysis (Denzin & Lincoln, 2005; Kvale, 1996; Larkin, Watts, & Clifton, 2006). The interviews were first screened for central and repeating themes and preliminary trends were conceptualized. Only those dimensions that were common to at least six (20%) participants were grouped under a more abstract higher order concept, based on its ability to explain and predict patterns of maternal perceptions (Schreier, 2012). The main categories and explanations which emerged from the interviews were further sorted into central, differentiated themes (Corbin & Strauss, 2007).

3. Results

Three central themes emerged from the interviews: (1) an association of maternal concerns for the child’s eating as well as body shape, and weight, with controlling feeding practices, (2) avoidance of eating in the family context, and (3) aggregated effects of the maternal eating disorder on some children. Within each theme, two main subcategories were identified. Table 1 presents the themes and subcategories, with representing quotes.
Theme 1: An association of maternal concerns for the child’s eating, shape, and weight, with controlling feeding practices
(a) Expectations for a slim and fit child

The majority of mothers with eating disorders reported a preoccupation with their child’s body shape, weight, and appearance as well as a concern that their child will become overweight or not be physically fit. These strong concerns appear to be linked with a significant role these mothers give to body weight in the schemas they have for which characteristics constitute their child’s well-being, based on their experience and values (Quotes 1–2). Many mothers shared their repeated, uncontrolled checking of the children’s body and nutrition. Some mothers were concerned about whether their fears surrounding their child’s weight and the dieting terminology they used to describe their toddlers were age-appropriate or “normal” (Quotes 3–5). The maternal concerns regarding the child’s weight also sometime brought about a desire for the child to be satisfied with low calorie intake (Quotes 2, 6).

(b) Many dilemmas about child feeding

Many mothers spoke about the links between their increased worries about their children’s weight and their confusion as to how to best feed their children. Some mothers reported high levels of control during feedings, aimed at restricting their toddlers’ intake and exploration of food. These behaviors included having short meals, delaying the introduction of solids, postponing autonomous eating and use of cutlery by spoon-feeding and placing the child in a high chair, and restricting any playfulness or exploration of food (Quotes 7–8). Mothers also expressed that their prolonged eating disorders affected the degree of certainty they felt in their decisions surrounding the types and amounts of food provided, introduction of new foods, and changing feeding routines (Quotes 9–11). The continuous feeding interactions inherent in a mother-infant relationship, caused some mothers to challenge their own axioms about child nutrition and regulation of hunger and satiety (Quotes 11–12).

Theme 2: Avoidance of eating in the family context
(a) Avoidance of handling feeding

Some mothers with eating disorders discussed attempts to avoid handling food and feeding their young children altogether (Quote 13). Mothers also expressed tensions caused by activities outside the home during which their child would eat (Quote 14). Other mothers shared their discomfort by providing their children varied foods, as well as deficiencies in their understanding of nutrition which could lead to insufficient consumption of nutrients by these children (Quote 15).

(b) Scarcity of family meals

The interviews revealed that for many mothers with eating disorders, family meals are a rare occasion as opposed to a regular part of the family routine. These mothers tend to eat different meals at a different time from their children. Often there are three dinners served in the same household—one for the children and one for each parent separately (Quotes 16–17). Mothers acknowledged a gap between their desire to model healthy eating habits for their children and their difficulty modifying their problematic eating patterns to what they think they should do (Quote 18).

Theme 3: Aggregate effects of the maternal eating disorder on certain children

Fig. 1. Semi-structured guide used to conduct interviews with mothers with eating disorders.
Table 1
Themes and subcategories from a content analysis of child feeding perceptions among mothers with eating disorders.

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<tr>
<th>Central theme</th>
<th>Subcategory</th>
<th>Supporting quotes</th>
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<tr>
<td>Theme 1: an association of maternal concerns for the child’s eating, shape, and weight, with controlling feeding practices</td>
<td>(a) Expectations for a slim and fit child</td>
<td>Q1: “For me a fat child is the scariest thing in the world. I’m scared to death he will be fat. Especially as a child. I know what it’s like to be a fat child, and that is one of the most horrible experiences a kid could have.” [ID16, 28 y/o with a 38 months old boy]</td>
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<td>Q2: “It’s OK when my kids eat massive amounts of food, as long as they’re skinny. My third child is chubby, and this takes control of me; it scares me. I feel as if my illness takes over there. I feel I pass my illness on to him, whether I want to or not. I pay attention to what he eats, and comment on his speed, eating time, the amounts …”</td>
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<td>Q3: “I see a very big difficulty in my relationship with this child because he’s more rotund … I feel a less warm attitude toward this child, because he eats a lot and because he loves eating a lot of carbs. Because he enjoys food, you see a child who takes pleasure in every bite, and it simply tortures me. With my other children who eat the minimum they need, I sympathize much more. I feel that I … [am] much less empathic to him.”</td>
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<td>(b) Many dilemmas about child feeding</td>
<td>Q4: “I’m constantly thinking about what she’s eaten. For instance, I go to bed feeling bad that today she ate only snacks, or that she did not eat enough in the last two days. I wanted to ask you if it’s normal … This is very stressful … I keep telling myself that it’s normal. In the handouts they give you in the well-baby clinics, it’s written that kids her age need to eat 600 mg of calcium every day. I know that in one slice of yellow cheese, there’s 200 mg, and in chocolate milk, there’s not much, and she doesn’t eat a lot of cream cheese. So I am constantly busy with calculations.” [ID23, 32 y/o with a 34 months old girl]</td>
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<td>Q5: “I hoped he would burn some calories once he began crawling.” [ID14, 34 y/o with a 41 months old boy]</td>
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<td>Q6: “He’s not a fat kid, he’s curved. He takes care of his looks and does not allow himself [to eat] without any limits. … He tries to decrease the amount of food that he eats.” [ID24, 24 y/o with a 41 months old boy]</td>
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<td>Q7: “She just wouldn’t take anything from me other than formula. When a friend of mine gave her Gerber, she would eat it, but from me she wouldn’t [eat it] under absolutely any circumstances. Today I understand that I showed disgust; I couldn’t see all that mess. Even today I cannot see the mess, the spreading of food. I couldn’t watch her handle the food, which I realized later was the normal and most natural thing that can be, and I just prevented her from doing so.” [ID28, 33 y/o with a 40 months old girl]</td>
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<td>Q8: “He eats too much and it drives me crazy! At some point I stop his lunch too, because a child must have some boundaries and he has a problem with that.” [ID20, 27 y/o with a 35 months old boy]</td>
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<td>Q9: “Food is still a very problematic issue between us … I still tend to feed him sometimes, or do it when he’s not aware of it, for instance while he is watching a movie. It’s clear that no one really wants to eat, so I prefer to feed him when he is distracted. One of my biggest joys is when I just put a plate in front of him and he eats …”</td>
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<td>Q10: “Even if I get a hold of myself and start any kind of treatment … It is difficult to act as a mother and to positively think of feeding my children. If I cannot seem to be able to decide what to eat myself, how can I choose food for them?” [ID06, 23 y/o with a 42 months old girl]</td>
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<td>Q11: “The transition to solid food was so difficult … I was anxious about the change in routine and adding something new [to the child’s menu]. I was nervous how much he would eat. I went by the clock since they told me to feed him every two hours. But it didn’t work, and he didn’t eat according to the clock … I completely did not trust his hunger and satiety system, and it’s the same also today. [Interviewer: “What do you mean by trust?”] I saw that three hours had passed, but even if he did not show any sign of being hungry, I did feed him …”</td>
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<td>Q12: “Sometimes they eat so much that I tell them ‘My goodness, it’s food all day long. Stop, it’s enough!’ We go often to the pool and I take a small bag with a sandwich and some stuff for them. At the end of the day, I return home with an empty bag and never understand: How come? We went out for less than four hours; do I need to take food for a week? How come?” [ID04, 35 y/o with 41 months old twin girls]</td>
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Table 1 (continued)

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<th>Central theme</th>
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<td>Theme 2: Avoidance of eating in the family context</td>
<td>(a) Avoidance of handling feeding</td>
<td>Q13: “I was extremely nervous when it came to feeding her. I had this wish that my mother would feed her and only then bring her to me, without me having to deal with it.” [ID07, 39 y/o with a 32 months old girl] Q14: “It's sometimes very difficult [to be outside home] since some people are eating pasta at the playground and I have to ask them: ‘please don't offer my girl any food, she has eaten already’. [ID18, 30 y/o with a 25 months old girl] Q15: “There was a time when Emma was problematic with food, and I didn't know that there's not much iron in schnitzel and chicken... I only realized it when she began eating chalk off the wall and I took her to the doctor for a blood test. Then I was told that red meat is richer in iron; I didn't know that at all.” [ID05, 34 y/o with a 31 months old girl]</td>
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<td>(b) Scarcity of Family Meals</td>
<td>Q16: “The one thing that really annoys me is when my husband asks what we are eating for dinner. You know this is my biggest problem. As far as I am concerned, it is perfectly fine not to eat anything, so don't ask me what we'll eat. And then we become very stressed in the last minute because time passes, no one prepares anything and there's no food [for the kids]. We just do not prepare food for a family dinner.” [ID28, 33 y/o with a 40 months old girl] Q17: “I usually make him fast food at home. I don't mess a lot with preparing food, I don't have either the strength or the desire to do so. I can cook, but the only day that I cook is Thursday, when I prepare food for the weekend...” [Interviewer: Do you regularly eat with him?] No, even if I eat what I've prepared for him, it's [during] the start of a binge, or even if it's not a binge, then I sit in the living room and eat fast. He sits next to the kitchen table and eats. We do not sit together and eat.” [ID12, 29 y/o with a 31 months old girl] Q18: “I rarely eat with him. I know it's problematic. We do eat together occasionally on weekends if we all eat out in a restaurant as a family. But me and I do not eat the same things, since he eats schnitzel and fries or kebab and fries or pizza, and I eat my regular food, which is always a salad... Sometimes he wants to share his food with me, and then I pretend to taste it. For the time being, I am managing to lead him on; I put his food in my mouth and when he isn't watching, I take it out.” [ID16, 28 y/o with a 38 months old boy]</td>
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<td>Theme 3: Aggregated effects of the maternal eating disorder on some children</td>
<td>(a) Children's awareness of the maternal eating disorder</td>
<td>Q19: “When he offers me a taste, I pretend to taste his food or I make up a reason why I can't eat it. But I know he eventually will understand... Once he didn't eat and I tried to urge him by saying: 'You know, [otherwise] you'll be weak,' and he replied: 'you didn't eat, you will be weak too!'... I can sense his questions coming soon: ‘Why do always you eat this kind of food while I eat something else?’” [ID25, 39 y/o with a 29 months old boy] Q20: “The kids see it; they follow me to the bathroom and ask me ‘what are you doing?’ They know well that you should not throw up after eating... I leave them in the living room and I go to the bathroom, but they follow me and open the door.” [ID12, 29 y/o with a 31 months old girl] Q21: I did plenty of [eating disorders] things in her presence, since I thought that she was only a little girl and wouldn't remember or understand anything. But the other day she followed me to the bathroom, and she's only three and a half years old, and she told me: ‘Mommy, you eat and then you do like that’ and she showed me a vomiting posture. I asked myself, how does she know? I never threw up in front of her; I binge in her presence, but I don't throw up.” [ID19, 30 y/o with a 42 months old girl] Q22: “[I think that] She started understanding that we're preventing her from eating as much as she wants, so she began stealing food... If I don't let her eat something, then she would just go later and take it, and then she would hide and eat it secretly. It makes me so sad because I see myself in her. I was also told not to eat certain things and I used to eat them sneakily. It saddens me, since this indicates that she is a younger version of me”. [ID11, 38 y/o with a 27 months old girl]</td>
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| | (b) Intensification of concerns and controlling behaviors in regards to girls | Q23: “I fear that somehow I will make my daughter feel that she is not pretty enough, not skinny enough... With my son this issue of looks and obesity bothers me much less, since it's a boy. It doesn't matter. He'll have a male's metabolism and even if he's a bit above his [normal] weight or even if he's extremely fat, no one will trouble him for that... I think that if she was a very skinny girl then it would be a lot easier for me... I'm afraid that if she is fat, then I won't be able to give her the feeling that I love her as I am supposed to love her or [she will feel] that I love her less because she's fat.” [ID10, 28 y/o with a 31 months old girl] Q24: “I honestly don't know, if I were to choose for my girl, to be fat or have an eating disorder; I don't know what I would prefer. I feel very bad for thinking this, I think it makes me a bad mother... When I feed them both [her son and daughter], I give him a much larger portion than the one she receives. Him I feed when he doesn't eat well, and with her, I insist that no one else would feed her... and the minute she doesn't want the food anymore, we take away her plate.” [ID18, 30 y/o with a 25 months old girl] Q25: “I felt somewhat ambivalent [when I realized I had a girl]... I was afraid that if I go on eating like that, it will project on her and she would have this problem as well. So it depressed me pretty much and then I thought that if (continued on next page)
(a) Children’s awareness of the maternal eating disorder

Mothers with Eating disorders reported that some toddlers expressed greater curiosity and understanding of the maternal eating behaviors than their sibling did. According to their mothers’ report, these toddlers were becoming aware of the maternal eating disorder at a very young age. The interviewees reported that a few toddlers verbally acknowledged the maternal symptomatic behaviors (Quote 19), whereas others showed preliminary imitations of their mothers’ behaviors without fully comprehending these actions (Quotes 20 – 21). The mothers expressed great sadness and concern around the effects of their eating disorder on their children’s behaviors (Quote 22).

(b) Intensification of concerns and controlling behaviors in regards to girls

All of the aforementioned themes emerged for both female and male offspring of the mothers with eating disorders, however a unique focus on daughters exists. Mothers who had children of both sexes reported greater feeding difficulties, increased food restriction, and more restraint from autonomous eating with their daughters. Additionally, the mothers disclosed that they made more comments about their daughters’ bodies than their sons’ (Quotes 23 – 24). Nonetheless, the mothers also expressed that concern about the impact of their eating disorder on their children motivated them to take steps away from their longstanding symptoms and towards recovery (Quote 25).

4. Discussion

Eating disorders have a deleterious effect on many aspects of functioning. The interviews in the current study with mothers with lifetime eating disorders reflect the complexities of the associations between the maternal eating disorder and the child feeding-related beliefs, concerns, and dilemmas. The themes that emerged in the interviews illuminate how these mothers navigate contradictory beliefs and actions that arise from both their eating disorder and from additional experiences and knowledge they have. The perceptions that were uncovered in this study - strong concern for the child’s weight, shifts between different stances about feeding their child, and increased anxiety and control with their daughters - are compatible with the existing evidence of the behaviors of mothers with eating disorders. These maternal perceptions can help us understand their motives and potential barriers to change, and be applied in interventions for mothers with eating disorder history and their children (Bryant-Waugh, Turner, Jones, & Gamble, 2007; Runfola et al., 2014; Tuval-Mashiach, Ram, Shapiro, Shenhv, & Gur, 2012).

The themes found in this study suggest that the mothers’ intentions are good, and they are attempting to provide their children with the most nurturing environment possible. However, their lifetime eating disorder makes them unsure how to best achieve this goal. Mothers reported that their eating disorder concerns and habits translated into disadvantageous feeding practices for their children, particularly in terms of food provision and daily feeding routine, as previously found in some studies (Farrow & Blissett, 2009; Squires, Lalanne, Murday, Simoglou, & Vaiivre-Douret, 2014). Our results add to the literature in illustrating that the mothers themselves often questioned whether they were doing the right and wrong thing for their children at the same time. Children internalize parental attitudes and behaviors in a continuous implicit learning process (Grolnick, Deci, & Ryan, 1997). Despite their good intentions, though, many mothers with eating disorders seemed unaware of this unintentional modeling and expressed surprise when their children acknowledged or imitated behaviors they had not revealed purposely (Palfreyman, Haycraft, & Meyer, 2013). In addition to direct modeling, the infrequent family meals and joint eating found in this study may also signal the child that eating is not an enjoyable activity, even when the mother does not directly comment on eating or weight (Ackard & Neumark-Sztainer, 2001).

Maternal psychiatric disorders may significantly affect child rearing practices and represent a risk factor for the development of mental disorders among children, beyond simply a genetic risk (Boyle & Pickles, 1997). Given that eating is a constant, recurring daily activity in the mother-child routine, an eating disorder has the potential to have a tremendously harmful impact on young children. Consistent with the findings of Satter (1990), the findings of the current study suggest a disrupted division of responsibilities in feeding among some mothers with eating disorders and their toddlers, in which feeding relies more on maternal cognitions, experiences, and routines than on the child’s self-regulation. These concerns and behaviors about feeding may precipitate future eating problems in their offspring (Watkins, Cooper, & Lask, 2012). Moreover, mother–daughter interactions that are tainted with greater worry for their shape, could be linked with a greater negative body image and eating symptomatology later (Cooley, Toray, Wang, & Valdez, 2008).

The current study should be viewed within that context of several limitations. This paper focuses on the maternal perceptions around feeding that are dissimilar to maternal behaviors and their actual feeding practices. It is possible that despite their concerns and dilemmas, the mothers interviewed in this study do not feed their children differently than parents with no eating psychopathology. In addition, the interviews focused on the mother-child dyad and did not address potential moderators, such as family and social support. For example, fathers may function as a protective factor if they are involved and supportive (Goodman & Gotlib, 1999). Moreover, it should be noted that a fairly narrow and probably a severe subset of patients participated in the study, and thus, the findings may not be applicable to less severely ill mothers. Most of the mothers who were interviewed had long histories of the disorder and were still actively symptomatic. Further, the sample size was small and it is unknown if data saturation was met. Lastly, it is unknown if the mothers who were currently receiving treatment for their eating disorder responded differently to the questions than the mothers who were not receiving treatment. Future studies should further explore moderating and precipitating factors, such as the length and severity of the maternal eating disorder and the extent of comorbidity.

5. Conclusions

The findings we present here intertwine two areas of research that should not be distinct: eating disorders in adults and...
childhood risk factors for developing eating disorders. Maternal perceptions appear to play a role in actual feeding behaviors and precipitate feeding and eating difficulties as well as comorbid difficulties among the offspring of mothers with eating disorders. Findings indicate that the maternal eating disorder history may compromise maternal thinking and prevent mothers from making healthy decisions for their children. Therefore, these children should be viewed as a high-risk group and the management of adult eating disorders should include an evaluation of the feeding processes of their young children as an adjunct to the standard assessment and treatment protocols. Respectful understanding of the language the mothers use to describe their perceptions and dilemmas in regards to feeding is a step in the right direction for any evidence-based preventive intervention programs targeting the risk factors of the children, maternal functioning, and child outcomes.

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References