



Research report

Does maternal history of eating disorders predict mothers' feeding practices and preschoolers' emotional eating? ☆



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ARTICLE INFO

Article history:

Received 7 June 2014

Received in revised form 29 October 2014

Accepted 31 October 2014

Available online 6 November 2014

Keywords:

Eating disorders

Feeding practices

Emotional eating behavior

Mothers

Children

ABSTRACT

We aimed to examine whether a maternal history of eating disorders predicted mothers' feeding practices and preschoolers' emotional eating patterns. Data were available from 4851 mothers and their children, who participated in a Dutch population-based cohort study (the Generation R Study). Maternal history of lifetime eating disorders was assessed during pregnancy using a self-report questionnaire. Mothers filled out the Child Feeding Questionnaire and the Child Eating Behaviour Questionnaire when children were four years old. Linear regression analyses were performed, adjusting for potential confounders. Of all mothers, 8.6% had a history of an eating disorder (2.5% anorexia nervosa (AN); 3.9% bulimia nervosa (BN); 2.2% both AN and BN). Compared to mothers without a history of eating disorders, mothers with a history of eating disorders, in particular AN, used less pressuring feeding strategies (standardized $B = -0.30$; 95% CI: $-0.49, -0.11$). Children of mothers with a history of AN had relatively high levels of emotional overeating (standardized $B = 0.19$; 95% CI: $0.00, 0.39$). Maternal history of BN was not related to mothers' feeding practices or children's emotional eating. Overall, the levels of emotional overeating among children of mothers with a history of eating disorders are noteworthy, particularly considering the young age (4 years) of participating children. This finding may reflect an effect of maternal eating disorders on the development of disordered eating patterns, but could also be subject to mothers' perception.

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Introduction

Eating disorders are chronic mental illnesses, with a lifetime prevalence among women of about 2% for anorexia nervosa (AN) and about 3% for bulimia nervosa (BN) (Smink, van Hoeken, & Hoek,

2012) and evidence for increasing incidence (Micali, Hagberg, Petersen, & Treasure, 2013). AN and BN are associated with an increased risk of psychopathology, medical problems, and premature mortality (Klump, Bulik, Kaye, Treasure, & Tyson, 2009; Polivy & Herman, 2002; Smink et al., 2012). Furthermore, there is evidence for an intergenerational transmission of eating disorders, such that offspring of women with eating disorders have a higher risk of developing eating disorders themselves (Bulik, Reba, Siega-Riz, & Reichborn-Kjennerud, 2005).

Women with eating disorders suffer from disturbances in eating patterns. AN is characterized by pathological fears of becoming fat, while in fact the body weight is abnormally low (American Psychiatric Association, 1994; American Psychiatric Association, 2013). A distorted body image (i.e. perception of being overweight), denial of having a dangerously low weight and an enduring desire to lose weight are core to AN. A distinction is made between the binge eating/purging and restrictive type of AN, differentiating those who engage in subjective binge eating and compensating

* Acknowledgements: The Generation R Study is conducted by the Erasmus Medical Center in close collaboration with the Faculty of Social Sciences of the Erasmus University, the Municipal Health Service Rotterdam area, the Rotterdam Homecare Foundation and the Stichting Trombosedienst & Artsenlaboratorium Rijnmond (STAR). We gratefully acknowledge the contribution of general practitioners, hospitals, midwives and pharmacies in Rotterdam. Conflict of interest: L.M. de Barse, A. Tharner, and O.H. Franco work in ErasmusAGE, a center for aging research across the life course funded by Nestlé Nutrition (Nestec Ltd.), Metagenics Inc. and AXA. The authors had final responsibility for design of the study, for collection, management, analysis, and interpretation of the data, and for preparation of the manuscript. No other authors declare a conflict of interest.

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purging behavior (e.g. self-induced vomiting and misuse of diuretics, laxatives, or enemas) and those who accomplish weight loss mainly by restricting their diet. Similar to the binge eating/purging type of AN, BN is also characterized by recurrent episodes of binge eating followed by compensating behaviors to prevent weight gain. However, as opposed to the subjective binges occurring in AN which in fact contain very few calories, binge eating in individuals with BN refers to eating a disproportional large amount of food, accompanied with experiencing loss of control over eating. Compensating behaviors include purging behaviors (purging type), or fasting and exercising (non-purging type). Like BN, binge eating disorder (BED) is also characterized by recurrence of binge eating episodes accompanied by feelings of guilt, embarrassment and disgust (American Psychiatric Association, 2013). However, in BED, these binges are not followed by compensating behaviors.

Women with eating disorders often have difficulties in emotional processing (Polivy & Herman, 2002) and may experience comorbid mood disorders as well (Hudson, Hiripi, Pope, & Kessler, 2007), partially explained by common familial factors which may cause both eating disorders and mood disorders (Mangweth et al., 2003). It has been suggested that emotional eating patterns index vulnerability for eating disorder psychopathology (Lindeman & Stark, 2001) and can be present in both AN and BN (Espeset, Gulliksen, Nordbo, Skarderud, & Holte, 2012; Ricca et al., 2012). Emotional overeating, usually referred to as emotional eating, is the tendency to eat in response to negative emotions such as anxiety, anger, frustration, or depression (Lindeman & Stark, 2001; Wardle, Guthrie, Sanderson, & Rapoport, 2001). Emotional undereating is the tendency to lose appetite and eat less when upset (Wardle et al., 2001). In women with BN, this is mostly reflected by the occurrence of binges in response to emotional distress (Ricca et al., 2012). Women with AN are likely to eat less in response to emotions (Espeset et al., 2012), although there is also evidence for elevated levels of emotional overeating (Ricca et al., 2012).

Considering the evidence for an intergenerational transmission of eating disorders (Bulik et al., 2005), it is important to enhance knowledge about the underlying mechanisms. One of these mechanisms could involve the transmission of pathological eating behaviors, such as emotional eating. Indeed, in children aged between 8 and 10 years, dietary restraint and concerns about being too fat were more common among those who had mothers with eating disorders (Jacobi, Agras, & Hammer, 2001; Stein et al., 2006). Furthermore, preschool aged children of mothers with a history of eating disorders experienced more eating problems such as extreme drinking or eating pace (very fast or extremely slow), frequent vomiting, and altered energy intake and weight development (Micali, Simonoff, Stahl, & Treasure, 2011; Micali, Simonoff, & Treasure, 2009; Reba-Harrelson et al., 2010; Whelan & Cooper, 2000). Evidence for patterns of emotional eating behavior among children of mothers with an eating disorder is scarce, but in a sample of healthy Dutch families with adolescent children (aged 13–16) a positive association was found between emotional eating patterns of mothers and their offspring (Snoek, Engels, Janssens, & van Strien, 2007). Furthermore, a mother's use of food to soothe her child – a feeding pattern relatively often seen in mothers with eating disorders (Patel, Wheatcroft, Park, & Stein, 2002) – predicted relatively high levels of overeating in response to emotional distress in another population-based study (Blissett, Haycraft, & Farrow, 2010). Together, these studies (Blissett et al., 2010; Jacobi et al., 2001; Micali et al., 2009, 2011; Reba-Harrelson et al., 2010; Snoek et al., 2007; Stein et al., 2006; Whelan & Cooper, 2000) suggest that children of mothers with a history of eating disorders may also respond to stress by altering their food intake, just like their mothers.

Regarding mothers' feeding practices, mothers with eating disorders are likely to use food as reward or comfort and have more conflicts with their offspring during mealtimes than women without

eating disorders (Patel et al., 2002). Recent population-based studies suggest that mothers with a history of eating disorders or with high scores on questionnaires measuring current eating disorder symptoms (e.g. Eating Disorder Inventory-2 (EDI-2)) may also have different feeding strategies (Blissett & Haycraft, 2011; Haycraft & Blissett, 2008; Reba-Harrelson et al., 2010), although evidence is still inconclusive (e.g. Haycraft & Blissett, 2012). Some studies reported that women with a history of BN and with relatively high scores on the EDI-2 subscale bulimia more often used controlling feeding strategies, like restricting children's food intake or pressuring to eat (Blissett & Haycraft, 2011; Haycraft & Blissett, 2008; Reba-Harrelson et al., 2010). This observation, however, is not supported by all studies (Blissett & Haycraft, 2011; Farrow & Blissett, 2005; Haycraft & Blissett, 2008; Reba-Harrelson et al., 2010). In general, a history of AN and EDI-2 subscales drive for thinness and body dissatisfaction were not related to these feeding strategies (Blissett & Haycraft, 2011; Haycraft & Blissett, 2008; Reba-Harrelson et al., 2010), only one study reported a positive correlation with restriction and pressure to eat (Blissett & Haycraft, 2011). However, despite their population-based character, most of these studies were limited by their small sample size ($N < 100$) (Blissett & Haycraft, 2011; Farrow & Blissett, 2005; Haycraft & Blissett, 2012). Further population-based research with sufficiently large sample sizes is needed to enhance understanding of the relation between mothers' eating disorders and their feeding strategies, as controlling feeding strategies may have adverse effects. Specifically, controlling feeding strategies have been implicated in children's energy intake and risk of overweight (Rhee, 2008).

The current population-based study aimed to enhance understanding of the consequences of maternal history of eating disorders for maternal feeding practices and children's emotional eating in early childhood. We hypothesized that particularly women with a history of BN are more likely to use controlling feeding strategies than mothers without a history of eating disorders. Second, we expected that the foundation of the intergenerational transmission of distorted eating patterns is laid early in life. Therefore, we hypothesized that already at 4 years of age, children of mothers with a history of BN have a tendency to overeat in response to emotional cues and as a consequence, have a relatively high BMI, while children of mothers with a history of AN have high levels of both emotional over- and undereating. Third, we aimed to explore if maternal history of eating disorders is specifically related to children's emotional eating or to other eating behaviors as well.

Materials and methods

Study design and procedure

This study was embedded in the Generation R Study, a population-based cohort study from fetal life onwards (Jaddoe et al., 2012). All pregnant women living in Rotterdam, the Netherlands, with an expected delivery date between April 2002 and January 2006, were invited to participate. The participation rate was estimated at 61%. Assessments included physical examinations and parental questionnaires (approximately 86% filled out by mothers). Written informed consent was obtained from all participants. The Medical Ethical Committee of the Erasmus Medical Center, Rotterdam, approved this study (MEC 198.782/2001/31). Further information is available elsewhere (Jaddoe et al., 2012).

Participants

In total, 5212 mothers provided information on their history of eating disorders and gave full consent for the postnatal phase of the Generation R Study. Those with missing data on all outcome variables were excluded ($N = 361$). However, the different outcome data

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