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Fathers and mothers with eating-disorder psychopathology: Associations with child eating-disorder behaviors

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ABSTRACT

Objective: A limited literature suggests an association between maternal eating disorders and child feeding difficulties, and notes maternal concern about inadvertently transmitting eating disorders. Thus, parents may be an important target for eating-disorder research to guide the development of clinical programs.
Methods: The current study examined differences in child eating-disorder behaviors and parental feeding practices between a sample of parents (42 fathers, 130 mothers) exhibiting core features of anorexia nervosa, bulimia nervosa, binge-eating disorder, or purging disorder, and a matched sample of parents ($n = 172$) reporting no eating-disorder characteristics.
Results: Parents with eating-disorder psychopathology were significantly more likely than parents without eating-disorder characteristics to report child binge-eating and compulsive exercise. Parents with eating-disorder psychopathology reported greater perceived feeding responsibility, greater concern about their child's weight, and more monitoring of their child's eating than parents without eating-disorder characteristics; however, they did not differ significantly in restriction of their child's diet and pressure-to-eat. Child body mass index z-scores did not differ between parents with versus without eating-disorder characteristics.
Conclusion: Our findings suggest some important differences between parents with and without core eating-disorder psychopathology, which could augment clinical interventions for patients with eating disorders who are parents, or could guide pediatric eating-disorder prevention efforts. However, because our study was cross-sectional, findings could indicate increased awareness of or sensitivity to eating-disorder behaviors rather than a psychosocial cause of those behaviors. Longitudinal research and controlled trials examining prevention and intervention can clarify and address these clinical concerns.

1. Introduction

Eating-disorder (ED) psychopathology can affect youth and adults across the lifespan, including men and women during the childbearing and child-rearing developmental period [1–4]. Because EDs are severe mental illnesses with the capacity to disrupt functioning [5], and tend to aggregate in families [6], examination of parents' ED psychopathology on the parent-child relationship and development of child psychopathology is essential.

1.1. Concerns of mothers with EDs

Much of the research on parents and EDs has focused on mothers [7] and sought to identify their parenting concerns. This had the dual aims of developing clinical interventions for mothers and preventing child EDs, particularly because mothers with EDs *seek* treatment to prevent or address negative effects of their personal eating disorder on their children [1,6,8,9]. Although mothers seeking support for parenting skills may be a select group [10], research has consistently shown that some mothers with EDs have significant concerns about parenting tasks related to feeding and body image [1,3,8,9,11] and the parent-child relationship more generally [1,10–12]. In particular, mothers with EDs report concern about transmitting ED psychopathology to their children by modeling, and also report difficulty managing their own psychopathology during food preparation and feeding [3,8,9,11–13]. Mothers' concerns about the impact of their ED psychopathology on the physical and psychosocial development of their children are shared by clinicians, as maternal ED psychopathology does appear to influence young children from infancy through adolescence [4,8,12,14–18].

1.2. Feeding problems with young children

Parenting concerns of mothers with EDs underscore the extent to which these mothers care for their children, as well as the absence of malicious intent around feeding difficulties and worry about child weight [1,3,10]. Evidence suggests these concerns have validity:

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maternal EDs produce somewhat impaired growth in infants, who are born 200 g lighter on average than infants of mothers without EDs [1,2,6]. Smaller birth size persists in very young children [19], although older children do not exhibit this size pattern [4,20]. In addition to their influence on young children's weight, maternal EDs appear to contribute to the development of child ED psychopathology [14].

Longitudinal and cross-sectional studies of mothers with ED psychopathology use varied definitions of EDs to define their population. Some studies have evaluated mothers with current, active EDs at full clinical threshold or subthreshold level [1,4,8,9,16,19,21]. Other studies have included mothers with historical EDs [3,4,11,13,20,22–24]. Still other studies have assessed ED attitudes and behaviors rather than diagnoses [14,17,18,23,25,26]. Despite this heterogeneity, overall, research consistently reports some negative physical or psychological effects of parent EDs on children. In one prospective study, mothers with EDs showed some unresponsive feeding practices, including irregular feeding schedules and using food as a reward rather than for nutrition, which was associated with infants' increased eagerness to eat [4]. Some studies also report that mothers with EDs have difficulty maintaining breast-feeding, potentially due to embarrassment or insufficient caloric intake to produce breast milk [6,9,12]. Mothers with EDs also use more dietary restriction than mothers without EDs [1,8,15]. However, other work has failed to show that mothers with EDs experience difficulty breast-feeding or restrict their child's intake [22].

1.3. Transmission of ED psychopathology

In addition to concerns about the influence of ED psychopathology on feeding, mothers have concerns about passing along their ED psychopathology to their child. Hypothesized mechanisms of the transmission of ED psychopathology include modeling ED attitudes and behaviors, or creating an environmental trigger for a child with a genetic predisposition to developing an eating disorder [6,8]. Behaviorally, mothers with EDs can have difficulty with food preparation, messy eating, and family meals [10,13], which leads to young children's awareness of maternal EDs [13]. Additionally, mealtimes include more negative comments and more parent-child conflict when there is a maternal ED compared with no ED [27], although this does not generalize to other parent-child interactions such as leisure play [6,28].

Both eating patterns and ED attitudes appear to be influenced by maternal EDs. There is some evidence that with their young children, mothers with EDs attempt to help their children lose weight [4], and regulate their eating to prevent overeating [1]. Children ages 3–9 of mothers with EDs show more health-conscious eating patterns than children of mothers without EDs [20]. Additionally, children as young as age 10 begin to show dietary restraint when their mothers have similar ED psychopathology, compared with children of mothers without EDs [16], which persists even when mothers are not present [1]. These parent-child attitudinal and behavioral links may be learned indirectly (child observation of parent behavior) or directly (child reaction to unresponsive feeding practices).

Restrictive feeding practices among mothers with EDs likely stem, in part, from concern about child weight. Mothers with EDs report greater concern about their child's weight and perceived overeating than mothers without EDs (e.g., [4]), and these concerns are communicated to their children (particularly daughters) in the form of encouragement to lose weight [1,8,13]. Mothers of children with EDs also have more ED characteristics themselves, and a longer history of dieting, although they do not differ from mothers of daughters without EDs in terms of weight or personal weight concerns [17].

Children of mothers with EDs also appear to learn ED attitudes. They show higher body dissatisfaction [29] and weight/shape overvaluation [16] compared with children of mothers without EDs, although it is important to note that the higher scores among children of mothers with EDs were below scores among children with clinical EDs and similar to scores of children with feeding difficulties [16]. This is also in line with assessment of children with early-onset eating and feeding disorders and their mothers, which showed more frequent maternal history of EDs among children with feeding disorders compared with EDs [24].

Potential child impairment due to maternal EDs reaches beyond the transmission of ED psychopathology to include increased negative affect overall [4], and increased risk of child psychiatric disorders [30] including both internalizing and externalizing disorders [16,31]. Importantly, there is initial clinical evidence that when parents and children receive treatment, catch-up growth can occur [1], although the potential benefit on child ED and general psychopathology is unknown.

1.4. Fathers

To date, strikingly little research has included fathers, despite fathers' expanding role in child-rearing and involvement in child feeding [7]. The research that has included fathers has focused on fathers who are part of a family in which the mother has an ED [13,21], rather than examining fathers' unique contributions. Some studies, building off a general psychiatric literature, have suggested that fathers can have a protective role against the transmission of ED psychopathology from mothers to children, particularly when they actively parent [13]. Conversely, paternal psychopathology can also play a negative role in the development of child psychopathology. For example, one study found that paternal psychopathology (obsessive-compulsive disorder and anxiety) together with maternal ED psychopathology was associated with internalizing and externalizing disorders in their children, and also found that maternal depression was only associated with internalizing and externalizing disorders in children when fathers were also found to have psychopathology [21].

Evaluation of fathers' ED psychopathology, although minimal, has shown that fathers have a similar impact on daughters' ED psychopathology to mothers. Both maternal and paternal ED psychopathology appear to be related to increased parental pressure for children to eat [23]. Additionally, greater paternal bulimic symptomatology was related to increased use of incentives to encourage eating [23]. Other research found that neither fathers' nor mothers' drive for thinness was associated with children's ED attitudes and behaviors [26]. Yet other work has shown a unique effect of paternal weight concerns on daughters' weight concerns [18]. Fathers' body dissatisfaction may be more related to unresponsive feeding practices for their sons, rather than their daughters, suggesting that ED psychopathology transmission may be most salient in father-son dyads and mother-daughter dyads [32]. Conversely, research on binge-eating among parents and children found that daughters were influenced by their fathers' (but not mothers') binge-eating [14]. Daughters may be more susceptible to interpersonal influences on binge-eating, whereas sons may be more susceptible to interpersonal influences on overeating [14].

1.5. Aim of the current study

The current study sought to examine similarities and differences among child ED behaviors and parental feeding practices between parents who endorsed core features of EDs (anorexia nervosa, bulimia nervosa, binge-eating disorder, or purging disorder) and parents who did not endorse core ED features at diagnostic frequencies (i.e., weekly). The existing literature on parents with EDs has two important gaps that the current study aimed to address within the context of evaluating the relation between parent and child ED behaviors. First, the current study attends to the dearth of information on fathers by including both fathers and mothers with and without core ED features. Second, the current study bridges the heterogeneity in patient populations within previous studies by including parents with current, core features of EDs. This offers a more distinct comparison with a non-ED group, rather than confounding ED severity (threshold and subthreshold) or timing (current or historical).