

Father's role in infantile anorexia

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Organic diseases account for only 16–30% of early feeding disorders. During the infancy period, mother-child relationship is in the center of feeding and disturbances in this relationship can also cause feeding disorders. Infantile anorexia (IA) usually begins within the first three years of age, but it has most commonly been observed to emerge between 9 and 18 months of age, a time during which babies transition to spoon and self-feeding. It is also worth noting that babies start to gain autonomy during this time frame. The present study discusses the case of an 8-month-old girl diagnosed with IA after ruling out food allergies, gastro-esophageal reflux disease, malrotation, and neurological problems. The patient was diagnosed with IA was treated with the relational regulation of parents and active participation of her father during the treatment process. It is found that mother-child relational disturbances and conflicts decreased dyadic reciprocity and non-appropriate affects in feeding times are associated with IA. Effective treatment strategies for non-organic feeding disorders might be developed by giving importance to maternal mental health and providing paternal involvement in baby caregiving.

Key words: father, infantile anorexia, maternal depression.

The prevalence of early feeding disturbances is 25–35% in children; however, feeding disorders which can be explained as inadequate intake of food that causes to failure to thrive or growth stunting are not prevalent.^{1,2} In pathogenesis, only 16–30% of early feeding disorders causes are organic diseases.³ Firstly, infantile anorexia (IA), which is one of non-organic feeding disorders, was described in a series of cases and expressed as a separation disorder.¹ IA usually begins within the first 3 years of age, most commonly between 9 and 18 months. These months are the time to transition to spoon and self-feeding. In addition, children start to gain autonomy during these months¹. IA, as explained by the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood Revised (DC: 0-3R, Zero to Three, 2005), is characterized by: (a) a child's refusal to eat adequate amounts of food for at least 1 month, and showing growth deficiency, (b) the child's lack of communicating its hunger and lack of interest in food, and (c) the child's food refusal which does not

follow a traumatic event and is not due to an underlying medical illness.⁴ During the infancy period, mother-child relationship is in the center of feeding and disturbances in this relationship may also cause feeding disorders.^{1,2} The relationships' dynamics in the environment of an infant affect the feeding of the infant and difficulties in family relationships are associated with feeding disorders.¹ Recently, researchers found that maternal psychopathology affects an infant's socio-emotional development, and specifically maternal affective disorders (e.g. depression) can be a risk for developmental delays in infants. In fact, maternal depression plays an important role in both attachment and eating disorders of infants.^{5,6} For example, mothers having a premature baby unexpectedly may perceive the situation as a loss and experience a grief like process. Symptoms like shock, neglect, rage, shame, guiltiness, depression, and social isolation may be observed, and such negative feelings may suppress the caregiving ability of the parents.⁷ Similar to mothers, fathers of babies may

also feel stress, helplessness, frustration, fear, and alienation.^{8,90} While they do not typically express these emotions, it has been observed that they usually conceal these emotions from their partners.^{10,11} The paternal contribution to a child's development begins during the infancy and regular paternal involvement provides a better father-child relationship and better cognitive and psychological development.¹² In fact, it has been found that disengaged and avoidant interactions between father and infant are associated with childhood behavioral problems.¹³

In this article the case of an 8-month old girl who was diagnosed with IA and whose mother was seriously depressed is presented together with the paternal contribution during the treatment process.

Case Report

The 8-month-old female infant, Baby E, has been presented with a 2-month history of feeding difficulties and difficulties in swallowing, vomiting, and vigilance. This baby was the product of a pre-term pregnancy (28 weeks) and she was an undesirable and unexpected baby, she was one of twins and Baby E also had two brothers. She had to stay in newborn intensive care unit (NICU) for 2 months. After coming home, she did not accept breastfeeding and started to be fed with formula. The other twin was still in NICU and it was very difficult for the mother to balance the twins in the house and in the NICU. After a while, the mother became very upset and angry and she began to shout at everyone. In addition, feeding times were very hard for both the mother and Baby E. Baby E began to not accept feeding and she started vomiting and stopped swallowing. The frequency of these events increased in time and in the meantime the family lost the other twin due to pulmonary failure. Following this event, the mother's maternal anxiety about losing Baby E increased. Feeding Baby E became more difficult after her twin died. Eventually, the family applied to child gastroenterology with symptoms of rejecting feeding, vomiting, not swallowing, and malnutrition. Baby E's mother is a housewife and her father is a worker. The couple's relationship was not very good, they usually argued. The results of the physical examination,

orofacial and neuromotor assessment were normal. Patient's weight and height were below -2 standard deviation. Firstly, organic etiology such as gastro-esophageal reflux disease (GERD), malrotation, or gastric outlet had to be ruled out. Superior gastrointestinal barium investigation results were in normal range; laboratory investigation results were normal suggesting that she did not have a food allergy. Anti-reflux treatment was started, but reflux was not eliminated. However, after one month Baby E did not give any response to the treatment and as a result an endoscopic investigation was planned. The endoscopic and histopathological examination results were normal. Eosinophilic esophagitis, gastritis and enteropathy were ruled out. After this, the mother consulted the child psychiatry unit. After three sessions, the case was evaluated as IA and the maternal anxiety and depression were high. Parents' partnership relation was bad and the father frequently spent his time outside of the family. When the mother applied to psychiatry, she was diagnosed with depression and anxiety disorder. She started sertraline therapy. Later on, during the treatment, the father was involved and participated in Baby E's feeding process and the father began to play with her. The fact that Baby E started spending more time with her mother and father has positively affected the child-parent relationship. Furthermore, parental conflict was decreased and triadic relations simplified the feeding of Baby E.

Written and verbal informed consent was taken from both parents for publication.

Discussion

The present study presented an infant diagnosed with IA after ruling out food allergies, GERD, malrotation, and neurological problems. The case was treated with the relational regulation of parents and active participation of her father during the treatment. Based on the results found in this case and supported with previous studies' findings, it can be argued that mother-child relational disturbances, conflicts, decreased dyadic reciprocity and non-appropriate affects in feeding times are associated with IA.^{5, 6, 14} These risk factors were in the caregiving environment of the patient who was a premature baby and had to

be in NICU for 2 months. As a result of her situation, the patient had some difficulties in dyadic relation with her mother. The mother had twins and both of whom were in NICU and this was considered to have brought out maternal guilt and anxiety and depression. At the same time, this may have caused mothers' insecure attachment to her twins. After the patient was out of NICU, she and her mother had lots of conflict in her feeding times and the mother was anxious because of the possibility of returning her child back to NICU and losing her. Then, when one of the twins died, the infantile anorexia (IA) occurred together with the grief of the mother the conflicts increased as well. Having a premature baby with possibly impaired health status as well as the separation from their vulnerable infant and loss of the expected maternity role are stressors which can result in anxiety and depression. Parents with high level anxiety commonly have difficulties in caregiving and feeding infants and therefore earlier parent-infant relationship may be delayed.¹⁵ Attachment disturbances were observed between the mother and child. While the child refused feeding, mother shushed her or began to cry. As mentioned above, mother-child dyadic relation was studied in a number of studies. However, father-child relations are also important in infants' development. While previous studies only focused on the mother-child dyad in development of childhood developmental and eating disorders, recent studies such as the present study provided evidence that there is an association between fathers' involvement and babies' feeding disorders.^{15, 16}

In Atzaba-Poria et al.'s¹⁶ study, lower paternal involvement and higher maternal involvement were found in families who had children with non-organic based food refusal. Less optimal interactions between child and mother or child and father during feeding and playing are associated with non-organic based food refusal.¹⁶ Finding adequate repairs and resolutions in possibly broken dyadic and/or triadic interactions and rebuilding those links through shared activities may be a solution for these families.

In our case all of the responsibilities of babies belonged to the mother and father was usually out of home. Then the father was included in

the treatment and feeding process. Feeding times were planned with both the mother and father. The father agreed to spend time with the patient during the treatment and he ended up playing with her at designated times. A recent study examined mother-father-child triadic interactions, during feeding and play time and in that study, families in the IA-group showed difficulties in expressing and sharing pleasure and positive affects.¹⁴ These results are similar to the results of the case presented in this study. After paternal involvement into the feeding and playing process, patient's weight gaining and feeding improved positively in the present study.

It can be concluded that disturbances in family relations have a critical role in cases diagnosed with IA and more effective treatment strategies for non-organic feeding disorders might be developed by giving importance to maternal mental health and providing paternal involvement in baby caregiving. In the treatment of an infant with feeding disturbances, nonorganic etiology, especially infantile anorexia (IA), may be considered only after ruling out organic reasons such as reflux, malrotation and neurologic disorders.

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