INFANT ANOREXIA AS A FEEDING DISORDER OF INFANCY

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S u m m a r y: Infantile anorexia was differentiated from inorganic eating disorders by Irene Chatoor, professor of Psychiatry and Pediatrics at the George Washington University, a world-renowned expert in the diagnosis and treatment of childhood feeding difficulties. Infantile anorexia nervosa is an eating disorder that has its onset during the early developmental stage of separation and individuation between the first six months and three years of life. In some cases, feeding difficulties are related to psychological factors, e.g. an incorrect relationship between the child and their carers. Pediatricians must consider the consistency of meal, the age and abilities of the child, abnormal behaviors and habits related to feeding the child, and disturbed parent-child interaction.
K e y w o r d s: infant anorexia, feeding disorder

INTRODUCTION

Feeding disorders are common pediatric problems with diverse etiology observed in approximately 25% of children up to 3 years of age. They are often associated with an organic disease, especially digestive, neurological, and circulatory. In some cases, feeding difficulties are related to psychological factors, e.g. an incorrect relationship between the child and their carers.

Eating disorders in infancy and childhood begin before the age of 3. They manifest as the lack of interest in eating and food, caprice, or selective food despite the provision of adequate food and the absence of organic diseases resulting in the observed problems. Such diagnosis can be determined when the disorder lasts for at least a month and leads to no weight gain, weight loss, or other health consequences. [1]

INFANTILE ANOREXIA

Infantile anorexia was differentiated from inorganic eating disorders by Irene Chatoor, professor of Psychiatry and Pediatrics at the George Washington University, a world-renowned expert in the diagnosis and treatment of childhood feeding difficulties. Infantile anorexia nervosa is an eating disorder that has its onset during the early developmental stage of separation and individuation between the first six months and three years of life. It is characterized by the refusal to receive food and a lack of interest in food, which can result in the failure to thrive. The infant refuses to eat in an attempt to achieve autonomy and control with regard to the mother, a maneuver that serves to involve the mother more deeply in the infant's eating behavior, and to meet the infant's need for attention. This is the period of development in which the child becomes more independent, acquires new skills, and is more interested in the environment. Food cessation is more pronounced than in the earlier period of life.

For food rebels their reluctance to eat is a way of expressing child's autonomy. It makes parents become concerned about the proper nutritional status of their child, and encourages people to try bribing, even intimidating while having food, and sometimes provokes 'forced' feeding, which usually worsens the problem. The infant's feeding is directed by emotional needs instead of physiological sense of hunger and satiety. The infant's temperament and maternal conflicts over control,

autonomy, and dependency appear to contribute to the eating disorder. Parents suffering from anorexia used to have problems with eating during their childhood, too [1, 2].

The infant refuses to eat either to express emotional hunger for their mother's attention, or to ensure their own autonomy, and express anger towards her. The infant must learn to differentiate between physiological sense of hunger and emotional needs so the caregiver needs to give conditional responses by offering food when the infant is hungry, and provide comfort when the infant is distressed [3]. The Parent-Child Play Scale is used to evaluate mother-infant interactions in two different caregiving contexts of a young child's everyday life, especially play and feeding. The scale was developed to complement the Parent-Child Feeding Scale. The Scale contains 4 subscales: Dyadic Reciprocity, Maternal Unresponsiveness to Infant's/Toddler's Cues, Dyadic Conflict, and Maternal Intrusiveness. It can be used for research or in clinical practice in the diagnosis and treatment of early feeding problems, to assess difficulties, and to monitor changes following the therapy. [4]

Several studies of Infantile Anorexia (IA) used the Feeding Scale [2, 5, 6] to better understand the behavior of infants with this feeding disorder, and to differentiate it from the behaviors of children with or without other feeding problems. The Feeding Scale has been widely used internationally to measure the quality of mother–infant/toddler interactions during 20-minute feeding in laboratory setting along five subscales: Dyadic Reciprocity, Dyadic Conflict, Talk and Distraction, Struggle for Control, and Maternal Non-Contingency. Some of these studies conducted on children aged 6 months to 3 years showed the feeding interactions between the children with IA and their mothers are characterized by low dyadic reciprocity, greater interactional conflict, and negative affect during feeding in both mother and child compared to the children without IA and their mothers. Symptomatic characteristics, both of the mother, especially depression and dysfunctional eating attitudes, and of the child, such as difficult temperament, anxiety/depression and withdrawal were significant predictors of mother–child interaction. Other studies have shown that the level of dyadic conflict between the mother and her child with IA can be a significant factor to differentiate IA from other feeding disorder subtypes.[4]

In a longitudinal study of feeding disorders in infancy the researchers found partial improvement in the nutritional status of the children with infant anorexia. However, they continued to show ongoing eating problems and, in addition, anxiety/depression and withdrawal, as well as rule-breaking behaviors and social problems. There were significant correlations between the infants' eating problems and their emotional difficulties and their mothers' higher emotional distress and disturbed eating attitudes. The researchers pointed out that the natural course of untreated IA is characterized by chronic difficulties in eating behaviors and emotional-behavioral adjustment in both the children and their mothers. [7]

Some literature reports focus on maternal psychopathology and child risk factors of IA. Analyses revealed that the IA-group showed higher scores in symptomatic characteristics both in the mother and child, and dysfunctional interactions during feeding compared with other children. The results confirm that a multidimensional assessment is critical in the evaluation of IA [8].

In another study, the researchers were examining the relative contributions of growth deficiency and psychosocial factors to cognitive development in infants and toddlers with IA. Children were evaluated by 2 child psychiatrists, and divided into 3 groups: infantile anorexia, picky eater, and healthy eater. All 3 groups were matched for age, race, gender, and socioeconomic status. The toddlers and their mothers were videotaped during feeding and play interactions, which were later assessed independently by 2 observers. On average, the toddlers with infantile anorexia performed within the normal range of cognitive development. However, the Mental Developmental Index (MDI) scores of the healthy eater group (MDI = 110) were significantly higher than those of the infantile anorexia (MDI = 99) and picky eater (MDI = 96) groups. Across all groups, the toddlers' MDI scores were associated with the quality of mother-child interactions, SES level, and maternal education level. It demonstrated that psychosocial factors, such as mother-toddler interactions are related to the cognitive development of toddlers with feeding problems and explain more unique variance in MDI scores than nutritional status [9].

Chatoor et al. [9] were the authors of a pilot study designed to examine whether infantile anorexia is associated with physiological dysregulation. Physiological parameters of heart rate and respiratory sinus arrhythmia were assessed across

three different scenarios: mother-infant/toddler interaction, infant/toddler-stranger interaction, and infant/toddler left alone with a toy while mother and stranger talked to each other in the other side of the room.

In all three scenarios, the toddlers with IA showed significantly shorter heart cycle (i.e. faster heart rates) than the controls. The children with IA showed consistently shorter heart cycle and were less adaptive in their physiological regulation than the controls. Such physiological dysregulation may constitute a tendency to less optimal internal homeostatic regulation of feeding in toddlers with infantile anorexia. [10]

Also Chatoor et al. [10] examined the relationship between specific maternal characteristics, maternal perceptions of toddler temperament and infantile anorexia. Mothers completed questionnaires that assessed their own eating attitudes, marital satisfaction, and their children's temperament. In addition, they did an interview that explored their attachment relationships. The mothers and children were videotaped during a feeding session, and infants/toddlers were weighed and measured. Temperament differentiated between infantile anorexics and healthy eaters, the infantile anorexics were assessed with higher difficulty, irregularity, negativity, dependence. Mothers of anorexics showed greater attachment and insecurity than mothers of healthy eaters, but they demonstrated neither overt eating pathology nor less marital satisfaction than the other groups. Thirty-nine percent difference in feeding conflict was explained by toddlers' diagnosis, temperament, and maternal characteristics. Twenty-one percent difference in toddlers' weight was explained by temperament and feeding conflict. The authors concluded that maternal characteristics and perceptions of their toddlers' temperament should be considered in the treatment of infantile anorexia. [5, 6]

There is a question, how infantile anorexia should be diagnosed? There is a study that confirms that infantile anorexia can be reliably diagnosed by pediatric psychiatrists. The evaluation of mother-infant interactions is a useful diagnostic tool. Two pediatric psychiatrists agreed in their diagnoses of toddlers with infantile anorexia, picky eating, and healthy, and good eating. The objective scale for the evaluation of mother-infant interactions showed a high level of agreement between two independent assessments [11]. For pediatrician the observation of the patient in the hospital ward is very important to determine correct diagnosis. It allows the quantitative and qualitative assessment of food intake, observation of the method of feeding, and analysis of other factors, such as the emotional involvement of caregivers and their anxiety related to the problem.

The psychological condition of the closest caregiver/guardian, most often the mother, may have a special meaning. A woman suffering from perinatal depression, overburdened with family or social problems, often externalizes negative emotions onto her child. Two styles of interaction between depressive mothers and babies can be distinguished. The first one is characterized by excessive stimulation, constant control, some kind of insistence towards the child (excessive swaying, insistent rocking on the hands). The other style is associated with the mother's withdrawal, maternal passivity, too little stimulation of the baby. [5, 6]

Treatment of infant anorexia is aimed toward helping the parents understand and promote the developmental process of somatopsychological differentiation. Initially, a behavioral-cognitive approach is used; however, parents who struggle with unresolved issues of dependency and control require further psychotherapy. [1]

CONCLUSIONS

Eating aberrations in young children are increasingly the source of parental complaints for medical advice. Particular attention is required by patients who have difficulty in feeding and delayed physical or psychomotor development. In such cases, the family doctor or pediatrician should consider the need for additional diagnostics. Bearing in mind that in some patients the health problem disappears spontaneously, the scope of the diagnosis is determined individually.

The complex etiology of feeding disorders is the cause of the involvement of other specialists in the diagnostic process. In the differential diagnosis of growth failure in infant/toddler, difficulties and feeding disorders resulting from abnormal feeding technique, inadequate portion size should also be taken into account. In addition, pediatricians must consider the consistency of meal, the age and abilities of the child, abnormal behaviors and habits related to feeding the child, and disturbed parent-child interaction.

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