A Mother's Complaints of Overeating by Her 25-Month-Old Daughter: A Proposal of Anorexia Nervosa by Proxy

Shuji Honjo
Associate Professor

Department of Clinical for Family Development
Nagoya University School of Education
Furo-cho, Chikusa-ku, Nagoya 464, Japan

The following is a report on a case of a 25-month-old girl brought in by her mother with complaints of overeating. The patient was referred to the Psychiatric Clinic of Nagoya University Hospital from the Department of Pediatric Surgery. The mother indicated the patient to have begun overeating before the age of 1 year. However, the patient was of low height and low body weight, and appeared, rather, to have been underfed. The issue was the mother placing severe restrictions on the child's diet, pathologically afraid of the child overeating. The mother seemed to have been suffering from a disorder similar to anorexia nervosa, although not typical. Her fear that her child might eat too much was believed to be a projection of the mentality characteristic of anorexia nervosa on to her child, which would justify labeling the child's condition anorexia nervosa by proxy.

It has long been apparent that eating disorders are on the rise among the young. At the same time, increasing numbers of women who are or have been affected by some type of eating disorder are becoming pregnant and giving birth (Franko & Walton, 1993; Stewart, Raskin, Garfinkel, MacDonald, & Robinson, 1987; Stewart, 1992). In this context, interest is also being directed toward the stumbling blocks encountered by such subjects in child-rearing (Lacey & Smith, 1987; Stein & Fairburn, 1989; van Wezel-Meijler & Wit, 1989; Woodside & Shekter-Wolfson, 1990). This paper reviews a patient who was brought in for overeating at 25 months by a mother assessed as having exhibited a condition comparable to anorexia nervosa before marriage, advocating the concept of anorexia nervosa by proxy.

THE CASE

The patient, Y.I., was 25 months old at the time of her first visit on February 13, 1989. She was brought in by her mother with complaints of overeating. Y.I. came from a family of 5 including her paternal grandmother, paternal aunt, and parents. Her father, a civil servant, had a cheerful disposition and liked children. Her mother was anxious and sometimes depressed. After graduating from university, she taught at a primary school for 3 years, resigning 2 years after marriage.

Childhood Background and Present Illness

The patient's weight was 2,530 g in the 10th month of gestation. She grew steadily, and was able to walk at 10 months and talk at 14 months. The baby was breast-fed, and she fed well.

The child's dietary disorder became apparent just before her first birthday. One day at 15 months old, she turned pale and experienced convulsions after overeating. Her abdomen distended with gas. At age 18 months, when she had eaten fruit in addition to two bowls of rice, some people called her a "monster." Also at 18 months, she was hospitalized and examined at the Department of Pediatric Surgery of Nagoya University School of Medicine. A poorly functioning transverse colon was diagnosed. To restore her control of defecation for preventing excess accumulation of gas, she began regular visits to the hospital as an outpatient. Meanwhile, the pediatric surgery department referred the mother and child to the Department of Psychiatry for Children, aware that psychological factors could be behind the mother's claim that the child was overeating. They underwent an examination with the author on February 13, 1989.

At that time, the mother reported, "I give my daughter only a bowl of rice, and I don't give her sweets. But she wants food so badly, and she wants to eat all day long. She will even eat an entire loaf of bread." However, the patient was then 79 cm tall and weighed 10.6 kg. She was, in fact, underdeveloped. It was suspected that the mother's excessive worrying, rather than the patient's overeating, was the problem.

TREATMENT

Joint counseling of the mother and patient was agreed upon to tackle the problem of overeating. They came in for counseling 2 weeks later. The mother said, "She eats everything within five minutes. Because she finishes her meals so quickly, she even tries to eat other people's meals."

For a while, they did not visit the hospital on a regular basis. At the end of May, the child's mother was hospitalized subsequent to a miscarriage, and the daughter was sent to stay with her maternal grandparents on June 1, where she began vomiting and became dehydrated. On June 2, the child was admitted to the hospital. Her weight fell from 10.5 to 8.5 kg. The mother, upon leaving the obstetrics ward, began taking care of the child. At the mother's request, the child was examined by the Psychiatry Department on June 16. From that day, we continued weekly counseling for 7 months until February 22, 1990, when the child was discharged from the pediatric surgery department.

During counseling on June 24, 1989, the mother related that the nurses were checking the amount of food her child was eating. This procedure was the result of ward staff doubting that the mother was feeding her child properly, judging from urinary volume and lack of weight increment despite the mother's word that the child was eating enough. The mother commented that, "I don't want to let her eat cakes and drink sweet soft drinks. I never let her eat chocolate. What shall I do if my daughter eats someone else's food and causes trouble, or if she becomes an overeater?"

Around that time, the mother started talking about her own childhood dietary habits. As a child, the mother had an unbalanced diet. In junior and senior high school, she did not have any overt dietary problems although she was underweight. At one time, she changed her lunch box to a smaller one after someone remarked that she ate a lot. Except for this incident, there were no serious problems in her college days either. However, 1 year after she began teaching, she became unable to eat due to stomach aches which persisted until 1 year after marriage. At that time, she was 160 cm tall and weighed 38 kg. She experienced amenorrhea for 6 months. Furthermore, the mother noted, "When I was pregnant, I was able to eat easily after going through a period of morning sickness. When I was told the food I ate was for the baby I was carrying, I was able to eat and it was delicious."

The child's condition gradually improved. However, during a counseling session on July 28, the mother said, "My child's belly inflates with gas in the evening. The nurses say that normal children look more or less like that. But I don't agree, because her belly deflates after a bowel movement." She was also displeased with the increased tubal feeding, saying, "The nurse told me to let her eat as much as she likes, but I don't want to feed her like a hog." The mother was still being particular about feeding, although the mother-child relationship appeared to be improving. The child was then 80 cm tall and weighted 9.1 kg.

In a session on August 18, the mother expressed her desire to leave the hospital, first making an analytical remark about her child's eating, saying, "My child became an overeater because I had been a nagging mother." However, she also remarked, "My daughter is no longer eating big meals. Now she eats only about half a child's meal," followed by, "I want to try behavior therapy to cure her overeating." Her remarks were completely contradictory. However, the child's facial expressions had improved.

On October 19, a rectum biopsy was conducted to check for organic disease in response to continued vomiting. The girl was placed on a 13-day fast for problems with the sutured area following the operation. During this time, the patient came to exhibit overdependence upon her mother, searching for her even for short absences. The mother herself complained of headaches, stomach aches, and sleeplessness, brought on by the stresses of caring for the child, becoming increasingly thin.

Some time later, several incidents provoked doubts among the ward staff that the mother was providing the patient as much nutrition as she claimed. Hence, the pediatric surgeon ordered the nurses to give the patient oral nutrients at the nurses' station. The mother was incensed by this change, commenting during counseling that, "I want to go to the nurses' station to give the nutrients directly to my daughter on my lap. I don't always want to play the role of disciplinarian. When I am with my daughter, the nurses ask me to leave. This hurts me very much." She was pale, complaining of serious sleeplessness and decreased appetite. However, the child, given proper nutrition at the nurses' station thereafter, gained weight to 10.5 kg, becoming increasingly active and lively.

The patient was allowed to go home for the New Year's holiday. She reportedly behaved life a "queen." According to the mother, "Although she insists on eating,

saying, 'I want this, I want that,' she doesn't actually eat, but instead says, 'I know I'll get spots if I eat them,' which is exactly what I have been telling her." The mother had begun to show some lenience. It appeared that she had acquired a deeper understanding of her daughter's condition. A decision was reached to release the patient in mid-February.

DISCUSSION

According to the pediatric surgeon, the patient's condition in this case may be diagnosed as chronic idiopathic intestinal pseudo-obstruction syndrome (CIIPS), so named by Maldonado, Gregg, Brown, and Green (1970). But in this case, the mother worried excessively about her daughter's swollen belly and vomiting, limiting the child's meals from fear of her overeating. The child was taken to the pediatric surgery department because of abdominal distension and vomiting. However, the pediatric surgeon determined that the problem was not in those symptoms but rather in the mother who, worrying too much about the child's belly and vomiting, excessively controlled the patient's food intake, eventually leading to a state of starvation. What the mother told me about the patient's eating habits during counseling sometimes differed from the words of the pediatric surgeon. The mother's complaints were a mixture of truth and falsehood, producing a conflicting impression, making it difficult to grasp what had actually taken place. For example, in discussing the results of a rectum biopsy on her child, the mother said that the doctor told her that there was an absorption disorder, although confirming this with the pediatric surgeon later on revealed that there was no organic abnormality in the rectum.

There are many similarities between the behavior in this case and that of Munchausen syndrome by proxy, as reported by Meadow (1977). Cases of Munchausen syndrome by proxy have been reported in which a mother deceives a doctor by telling false stories about her child's disease record, intentionally administering excess substances, or secretly changing test specimens such as urine samples. Such cases are now drawing attention as examples of child abuse. Although differences do exist between cases of Munchausen syndrome by proxy, wherein mothers deliberately deceive the physician and this case in which the mother exhibited no such attempts, it is not impossible to label this case Munchausen syndrome by proxy. However, the following further support the proposal of anorexia nervosa by proxy.

The main complaint in this case was overeating, where in reality, the mother's limitation of food intake drove the patient into a state of starvation. However, although the child's weight was extremely low for her age, it can be assumed that the symptoms of this case do not apply to the diagnosis of bulimia nervosa or anorexia nervosa as outlined by the 4th ed. Of the Diagnostic and statistical manual disorders (DSM-IV; American Psychiatric Association, 1994), because children this age do not harbor desires to become slim or fears of becoming obese.

The mother, on the other hand, began suffering from stomach aches 1 year after starting her job. She could not eat, and consequently lost weight. Amenorrhea continued for nearly 6 months. The mother did not clearly state desires to be slim, fears of obesity, or distorted body image. Therefore, this case does not meet the diagnostic criteria of DSM-IV anorexia nervosa. However, it can be inferred that the mother did have such inclinations which may have been behind her reluctance to eat. Therefore, the mother's condition was suspected to be similar to that of anorexia nervosa.

Concerning the patient, the mother's complaints were as follows: Even though the mother limited the patient to insufficient meals, she was extremely afraid of the patient overeating. She feared that the patient's appetite might become uncontrollable. She expressed her worries in asking, "What if my daughter eats someone else's food and causes trouble? What if she becomes an overeater? What if she becomes a scavenger of leftovers when she enters elementary school?" Although the pediatric surgeon told her the patient could not leave the hospital unless she gained weight, the mother would not accept any weight gain. Obsessed with her belief that her daughter had a swollen belly, she continued with the complaint despite assurances from the doctor and nurses. Such complaints point to the mother's distorted image of her child's body. Also, the mother weighed the patient repeatedly and secretly during the week. She abhorred the idea of giving sweets and the like to the patient. In these ways, the mother's behavior and mental state coincide with the symptoms of anorexia nervosa. It is believed the mother's psychopathology, characteristic of anorexia nervosa, was projected onto the child, resulting in symptoms affecting the child as a proxy, both justifying and calling this case anorexia nervosa by proxy, in the manner of Munchausen syndrome by proxy.

Incidentally, the problems arising in child-rearing by mothers who have been afflicted

with eating disorders are gradually becoming a topic of attention. Lacey and Smith (1987) report that 15 % of mothers with bulimia nervosa attempted to slim down their babies within the first year of life. Van Wezel-Meijler and Wit (1989), conducting a study on children of mothers with anorexia nervosa, report seven cases among three families exhibiting characteristics closely related to the mother's anorexia nervosa. All seven cases exhibited undernutrition and growth delay. In particular, a distinct fear of overfeeding was evident in the mother of one case, while all cases appeared to harbor problems comparable to the case under discussion in this paper. Stein and Fairburn (1989) report that among five cases of mothers with bulimia nervosa raising children between the ages of 15 months and 6 years, three cases exhibited extreme concern regarding the physique and weight of their children, attempting to hold down their weighs as much as possible.

Judging from the above reports, it is believed that cases comparable to that presented in this paper are not uncommon, even if they do not present symptoms as typical as these. And for this express reason, it is believed that the problem presented herein holds the possibility of becoming a large issue in child-rearing by women with eating disorders.

REFERENCES

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Franko, D.L., & Walton, B.E. (1993). Pregnancy and eating disorders: A review and clinical implications. *International Journal of Eating Disorders*, *13,* 41-48

Lacey, J.H., & Smith, G. (1987). Bulimia nervosa: The impact of pregnancy on mother and baby. *British Journal of Psychiatry*, *150*, 777-781

Maldonado, J.E., Gregg, J.A., Brown, A.L., & Green, P.A. (1970). Chronic idiopathic intestinal pseudo-obstruction. *American Journal of Medicine*, *49*, 203-213.

Meadow, R. (1977). Munchausen syndrome by proxy – The hinterland of child abuse. *Lancet*, *2,* 343-345.

Stein, A., & Fairburn, C.G. (1989). Children of mothers with bulimia nervosa. *British Medical Journal*, *299*, 777-778.

Stewart, D.E. (1992). Reproductive functions in eating disorders. *Annuals of Medicine*, *24*, 287-291.

Stewart, D.E., Raskin, J., Garfinkel, P.E., MacDonald, O.L., & Robinson, G.E. (1987). Anorexia nervosa, bulimia and pregnancy. *American Journal of Obstetrics and*

Gynecology, *157,* 1194-1198.
van Wezel-Meijler, G., & Wit, J.M. (1989). The offspring of mothers with anorexia nervosa: A high-risk group for undernutrition and stunting? *European Journal of Pediatrics*, *149*, 130-135.
Woodside, D.B., & Shekter-Wolfson, L.F. (1990). Parenting by patients with anorexia nervosa and bulimia nervosa. *International Journal of Eating Disorders, 9*, 303-309.