〈Case Study〉

Eating Disorders and Intergenerational Transmission

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Abstract : Much attention has been paid to the difficulties females with past or present eating disorders encounter in raising children. This paper illustrates the clinical features of intergenerational transmission of interrelationship in a mother with a history of eating disorder and her infant, and discusses preventive strategy for this phenomenon of intergenerational transmission. Characteristics of mother-infant interaction shown in this mother's child-rearing were : (1) difficulty in accepting his dependency needs, (2) little pleasure in playing with her child at the sensory-motor level, which suggested some disturbance in body image, and (3) overly high ego ideals giving rise to unreasonable expectations of her child. For resolving the child-rearing difficulties faced by the mother and to prevent intergenerational transmission of the mother's psychopathology to her child, mother-child psychotherapy was provided for promoting mother-child interaction and for altering the mother's inner representation of children formulated through the mother-child relationship with her own mother.

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Introduction

Long-term prognoses for eating disorders are far from pessimistic (Tolstrup et al., 1985), and many such subjects go on to become parents and experience child-rearing (Brinch, Isager & Tolstrup, 1988). However, it is also known that many difficulties arise when such patients actually become involved in child care (Woodside & Shekter-Wofson, 1990). The mother-child relationship is deeply associated with the onset of eating disorders, but in recent years, the aspect of how the psychopathology of such subjects with past or present eating disorders is reflected upon the mother-child relationship when they undertake child-rearing (Stein et al., 1994). In other words, great interest is being focused upon the reality of intergenerational transmission of the psychopathology of eating disorders, both as a phenomenon, and in terms of preventing such transmissions.

We have been conducting mother-infant psychotherapy from the standpoint of relationship disturbances (Sameroff & Emde, 1989) between mother and child for

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treatment of cases in which mother-child relationships are particularrly difficult to establish (Kobayashi et al., 1997). And recently, we have experienced a case suspected of developmental disorder whose mother had a history of eating disorder with onset before marriage. That the mother in this case had such history was discovered accidentally during the course of therapy, but the mother's psychopathology was seen directly reflected in the mother-child relationship as captured through the mother-infant psychotherapy. This paper clarifies how the psychopathological characteristics of subjects with eating disorders are reflected in child-rearing behavior, and discusses methods for prevention of intergenerational transmission of the psychopathology underlying eating disorders.

Case Presentation

Subjects

The subjects of this report are child Y, male, 3 years 2 months at first visit, and his mother, aged 31, although the following passages deal primarily with the developmental history of the child. Primary complaint : does not speak, howls, will not respond even upon being addressed directly. Family constitution : father (office employee), mother (full-time housewife), the subject, and younger sister (aged 1 year 2 months).

1. Developmental history

No problems were noted during gestation. Delivery was normal at full term. Birth weight : 2,624 g. Child Y was born with his eyes open, and an impression remains of this child alone continuing to peer around himself while other newborns slept. No problems were noted in the perinatal period. His spine stabilized between 5 and 6 months. First steps were taken at 1 year 3 months. The presence of people-shyness is uncertain. The subject was raised on a combination diet of breast milk and formula. Night crying was evident up to around 6 months, and taking care of the child was not easy for he would not go to sleep unless held. He showed no interest in toys. At age 1, bringing a doll close to him elicited no interest, not even to look at the person holding the toy. On the contrary, seeing him avert his eyes each time alerted the mother to something being amiss.

Starting to walk at 1 year 3 months, he took to moving about restlessly, showing no interest in playing with toys. At 1 year 6 months, he enunciated words such as "*To-to*" (father), "*Ka-ka*" (mother), and "*Oka-e-ri*" (welcome home).

From 1 year 11 months, the subject started screeching constantly, and ceased speaking the words he had acquired. The screeching became increasingly pronounced past age 2. He also ceased to respond to being called by name. Whereas he had previously greeted his father returning in the evening with the words "*Oka-e-ri*", he took to returning to whatever he was doing without a word upon setting sight on his father. This also imparted the sense of something being wrong to the parents.

Playing for the child was endless repetition with little variation, rarely involving toys, while strong interest in numbers and written words was evident.

At 2 years 6 months, although the mother had been meaning to seek advice when she took him to a health examination for 3 year olds, pressed by those around her to seek help as soon as possible, she visited a local health center where she was referred to a welfare center for the disabled. Diagnosed by a pediatrician as developmental disorder [mental age 1 year 6 months by the Kyoto Scale of Psychological Development (Ikuzawa, 1985)] , mother and child was enrolled in a special day-care type of nursing program. At the time, the subject was 91.0 cm in height, and weighed 13.1 kg.

At 3 years 1 month, the paternal grandmother strongly persuaded the parents to visit a university hospital, out of deep concern for her grandson. The parents took child Y to a psychiatry clinic at N University, where the diagnosis was autism. With the informed consent of the parents, the child was placed in a double-blind study on THBP (tetra-hydro-biopterin), although it was later revealed that the child had been receiving a placebo.

Shortly thereafter, the child was referred to the author by his teacher at the nursing facility, greatly concerned over the subject's behavior.

2. Characteristics of the mother-child relationship noted at first visit

The mother, small in frame, appeared very young in light of her age. Perhaps due to the large burden child-rearing had become for her, she appeared to be viewing her child with detachment. Child Y had no meaningful words. Speaking to the child did not elicit any response one would normally expect. Actions indicating he was alone in his world were evident.

On the other hand, it could be seen that much of child Y's attention was directed toward his mother, although he seemed unable to approach her directly. He would climb up toy stairs in the play therapy room, or gaze at his reflection in a mirror. He displayed no interest in the view outside the window. He would then nonchalantly approach his mother, but his mother was unable to respond appropriately to such moves. In due time, the child would start pinching or beating his mother, but she would reject his approach needs with a curt command of "Stop it! Can't you see that hurts?", unable to capture the meaning behind his aggressive behavior. It could be seen that child Y harbored desires to approach his mother amidst feelings of hesitation, and left one with an impression of the ambivalence he was feeling at being unable to approach his mother directly.

Incidentally, the father had had almost no direct involvement in child-rearing up to that point, and was a distant figure in the household. However, this is hardly an exception for a Japanese family. On the other hand, the paternal grandmother had always shown great concern for her grandson, and had been actively offering advice in many ways.

3. Diagnosis and indicated therapy

Given the difficulties in communication and loss of meaningful words, subsequent disturbance in mother-child relationship, and localization of interest and strong interest in written characters which was later confirmed through the process of

therapy, child Y's own developmental problems were diagnosed as autistic spectrum disorder. In addition, because strong bewilderment was noted in the mother unable to capture the meaning of Y's behavior, it was determined that the relationship between the two required attention. Thus, therapeutic intervention was attempted from the standpoint of relationship disturbances (Sameroff & Emde, 1989). The first half of therapy was conducted in a play therapy room at a welfare center for the disabled, and the latter sessions in an interview room at a psychiatric clinic, accommodating the author's needs. Sessions lasting 50~60 minutes were scheduled every other week, which were continued for the first 11 sessions, after which they were switched to weekly sessions, all sessions being conjoint therapy of mother and child, conducted by the author throughout.

4. Therapeutic course

Stage 1 : Alleviation of approach-avoidance motivational conflict (sessions 1~4)

As described above under "Characteristics of the mother-child relationship noted at first visit" (session 1), child Y displayed pronounced approach-avoidance motivational conflict (Richer, 1993), for which the author decided on a holding session, judging that cultivating the mother's capacity to accept and embrace her child was indispensable. Although only for the last 30 minutes or so of the first session, the author persuaded the mother to hold Y in her arms, timing the action to when Y naturally approached his mother. The mother's act of holding her child was awkward, so much so that the author had to stay by her side to help her hold him comfortably. At first the child struggled ferociously refusing to be held, but the resistance gradually subsided, until the physical comfort of being held became visible in his features

Following that first session, Y came to demand being held by his mother whenever they went out together. The mother did not appear happy with this change in Y, but the author advised her to "hold him as much as possible" (session 2). The child's behavior towards his mother in the interview setting became more natural, and he was seen to approach her smoothly without hesitation. When the author was working with the mother, the child would repeatedly climb on to his mother's lap and then get down again to play on his own. Indications of will in the form of actively pointing his finger at the author or the mother in attempts to solicit words were frequently seen. As such, in contrast to the dramatic dependence upon his mother that the child began to show in just a few sessions, the mother's display of bewilderment, not fully appreciating the change in her child, left a deep impression (session 3).

Perhaps due to heightened curiosity, the child's demands to go out increased. Y's favorite pastime was looking at the designs and symbols on discarded snack wrappings he found outdoors. He was particularly fond of numerals. The mother was unable to adjust her behavior to accommodate Y's interests, even displaying outright offense at Y's interest in such things. She expressed her feelings towards Y with irritation, saying, "I never had anyone play with me as a child either. I think I spent most of my time quietly, alone. That's why I don't know how I should be dealing

with him", or "Shouldn't I be trying to get him to sit down and do something?" (session 4).

Stage 2 : The mother's introspection (sessions 5~11)

From the fifth session, Y came to demand what we called "hammock" play, in which the mother and author would each hold the child's arms or legs, and swing him from side to side, imitating a hammock. Pointing to the pages of a picture book, he would emit sounds, ("Ah, ah") trying to get his mother to respond with words. Such displays only prompted the mother to become even more pessimistic, despairing that such action was still all that her son could manage. The author took up such feelings harbored by the mother in therapy. The mother then started exhibiting an introspective attitude, relating that she had suffered from adolescent emaciation before marriage. It was a sudden and unexpected confession by the mother (session 5). The mother then said, "Dealing with this child, I am struck by how uninterested I am in him. There are times when I think perhaps our feelings our out of sync", relating her attitude towards her child introspectively. Asked about the association between her disorder and her present child-rearing, she replied, "I am raising him just as I was raised myself. I've always been angry with him. My mother was always angry with me, too. So I was always anxious to please, behaving as my mother wanted me to, constantly wary of her moods. Subsequently, I was a good child ...". In this manner, the mother gradually became aware that there was something disturbingly similar between her own attitude towards her child, and that of her mother toward her (session 6). As for child Y, the "hammock" play was all he had been demanding up till then, but he gradually started taking interest in fiddling with pens, stamps, and other such objects on a desk in the play room. However, seeing the child having trouble handling a pen, the mother was unable to lend a hand in appropriate support. Successfully using the pen with a little help from the author, the child would respond with delight. Although showing interest in repeating the act on his own, he would hesitate, perhaps out of fear of failure. Relating this to the mother, i.e., how the author interpreted the child's actions, the mother responded overlapping her upbringing and her child's condition in recollecting introspectively, "I simply listened to what my mother said until I became emaciated. Thus, I never had to think things through or act on my own volition. So I didn't know what to do when I started working and had to work things out on my own. What others found a matter of course, I had no clue as to what needed to be done. Taking care of my child was the same, and in the beginning, I had no idea what I had to do. During hospitalization in hospital H, I was forced to keep a journal, which was most distressing (Fukamachi, 1987). It was really hard for me to express my own ideas" (session 7).

In the following few sessions, mother-child interaction showed no smooth developments, being a repetition of advances and retreats.

Stage 3 : Promotion of mother-child interaction (sessions 12~14)

Due to circumstances at work on the part of the author, sessions in the play therapy room at the welfare center was moved to a normal consulting room

(equipped with a chair and examining bed) in a psychiatry clinic (session 12). And because increasing the frequency of therapy was felt to be desirable, weekly sessions were scheduled from this point on. Child Y showed no anxiety stemming from this change in setting, and approached the author with joy as soon as he set his eyes on the author in the new setting. The child came to utter words actively, saying "Paa-shu" (meaning "bus") repeatedly. Hearing that, the mother commented "He's talking about a bus", but did not appear particularly happy seeing the change in her child, now starting to speak eagerly. Noting what could be called a depressive state in the mother, the author inquired after her feelings, "You seem to be sluggish today", to which she responded, "I seem to be venting my frustrations on my child all the time ..." Asking, "Is the psychological environment at home that bad?", she would respond, "My husband won't say or do anything. Even if I want to go on a family outing, my husband refuses to lend a hand. My husband says he doesn't want to because the child won't listen to him. And because my husband is like that, I end up venting my frustrations toward him on my son. My husband was raised by his parents from early infancy, but it seems his mother rarely looked after him herself having a demanding job, and I hear it was his aunt who took care of him most of the time. It appears that eating together as a family of four was something he only experienced a few times. Growing up in a family which was always acting separately, my husband seems to believe that that is the natural state for a family to be." However, even while voicing her dissatisfaction with her husband, she also indicated that her feelings regarding marriage per se was not negative, saying, "My revulsion towards sex life was strong even after marriage. But I am grateful to my husband that I was able to have a child."

Because the child would always demand the same mode of play with the mother, she would end up displaying disgust, commenting, "Again". When the author intervened, "You seem to be somewhat reluctant dealing with your son", she responded, "When (this child) becomes all excited, I worry that he might stay that way forever. So I become anxious if I don't adopt a somewhat detached attitude", revealing for the first time her strong bewilderment at experiencing unity with her child through play. Leading the mother through finger-play with her child and spinning the child round-and-round in a chair, child Y exhibited emotional excitation, leading to many instances of impromptu speech. Seeing such changes in the child, the mother came to voice optimistic evaluations, saying "I seem to have come a long way in playing with my child compared to a year ago". Even so, wariness bordering on the hypersensitive that demands to have his mother play with him might be rejected still remained in the child (session 13).

Y's utterance of words became more pronounced in proportion to his widening interests. However, watching the child earnestly enunciating "Ha-ha", attempting to say "Ha-na" or "flower", pointing to flowers in a vase in the examining room, the mother would say, "He can't even say "Ha-na", in an almost demeaning tone. Seeing her child left her with only a strong impression of the delay in his development, and capturing Y's slow but steady growth with joy was still difficult for the mother (session 14).

Stage 4 : The mother's depression and subsequent recovery (sessions 15-21)

The mother fell into deep depression, and voiced her anxiety in tears. She related how going to pick up her son at the nursing facility, he would not come to her, but go to some other mother instead. Taking him shopping, there too, he would trail after some other parent. Feeling as if the child was rejecting her, the mother related how much pain Y's impartiality was giving her. But in the interview setting, even when Y approached the mother, all she would do was to turn him away saying "Go play by yourself", unable to accommodate his approach. The author was unable to intervene effectively, even while empathizing with the mother, and the situation escalated into the mother saying "It's this child who's making me this way. The cause is this child himself." Witnessing such violent emotional outbursts by his mother, the child would stand by as if paralyzed by fear, presenting a most pitiful picture of mother and child. Because the mother was clearly exhibiting depression, the author suggested pharamacotherapy. With her consent, she was immediately started on 30mg clomipramine/day (session 15).

Medication was terminated after one week, due to anxiety expressed by the mother regarding the somnolence it induced. However, it was impressive how much brighter she had become compared to the week before. She herself related, "When my son comes to me with some demand, I try to accommodate him as much as possible", revealing a positive attitude in sharp contrast with the previous session. Pointing this out to her, she related how her son's grandmother was strongly recommending that Y be placed on medication. However, she herself having no wishes to subject her child to drugs, she related how in discussing this with her husband, he had agreed with her. She described with pride how she had been able to discuss Y with her husband and reach a decision between themselves, not bowing to the grandmother's views. It was truly astonishing that given this change in the mother's psychological condition, Y pointing out the clinic's window and saying "*ko-ki*", for "*hi-ko-ki*" or "airplane", prompted her to say "You mean *hi-ko-ki*", in a gentle voice, catching on to what it was he was trying to say right away (session 16).

Y's self-assertion was becoming visibly clear, and he started using words as a means of communication, as in saying "*Ki-te*" ("come here") to his mother and author, gesturing towards a sofa. The mother was also becoming capable of enjoying playing with her son, coming to notice that Y's various "words" had meanings, such as "*Ha*" for "*Ha-na*" (flower) or "*Ha*" (leaf), "*Ka-gi*" for "*Ka-gi*" (keys) or "*Ku-tsu*" (shoes), and "*Ki-te*" for "*Ki-te*" (come), etc., to the point of being able to interpret his words for the author (session 17). The favorable change in her son appeared to create some room for introspection in her mother's mind, and she related "I think I've been dealing with this child in much the same way until now—when he was 0, 1, or 2 years old. I was just taking care of his physical needs. I had no idea how I should be dealing with him" (session 18).

Y's self-assertion grew steadily stronger, and his way of playing became increasingly energetic. And with these changes, he came to express initial resistance to every disciplinary move (such as donning or taking off clothing), something which he had not done before. The mother often complained that Y was becoming difficult to

handle, but her complaints were nowhere as serious or pressing as before. Excited riding piggy-back on his mother, he once arched backwards, so much so that he ended up hitting his head on the floor. The incident was fortunately nothing serious, and the mother was able to respond with confidence to his pain with a little rhyme, "Pain, pain, go away". Perhaps conscious of this change in his mother's attitude, upon colliding with a window, he greatly exaggerated his pain, and ran to his mother for comfort. To this, the mother was able to take him in, responding most naturally saying, "What's the matter?" (session 20).

Stage 5 : The mother's insight (sessions 22~34)

Instances of child Y stopping by the receptionist's desk at the clinic increased, and he spent less time clinging to his mother. The mother did not view this change in Y with the anxiety she used to express. "I had always wondered why this child would purposely not do what I told him to do. Now I think that's just the way kids are. Personally, I had always thought it better to listen to my mother, and had always done whatever she told me to right away. But then, I ran into problems upon entering college where I had to do everything for myself." "So, I had always acted as a 'good child'. But I think my emaciation was the result of wanting to attract attention. The idea of rebellion or not doing something on purpose is something I can't really relate to." In such ways, the mother appeared to have established enough peace of mind to allow for introspection of her own past (session 22). However, although the mother's involvement in playing with her son had become quite active, she rarely responded physically even while moving around with him, and there was a notable absence of vocal markers (Newson, 1978) which would energize mother-child interaction through the emittance of words and sounds in time to movement (session 24).

Perhaps increasing interaction with her child was becoming a burden to the mother, which she phrased frankly as, "I had always thought all I needed to do was talk to children ... physical play is agonizing." Pointing out that she held high ideals in certain respects, she noted, "You're right. And both my son and I end up feeling awful. I find it difficult to bring myself to praise him. Seeing him unable to do something, I end up despairing that he is just hopeless, no matter how hard he is trying. I think I grew up being told that (by my mother) myself" (session 26). Furthermore, "I find myself just following his actions with my eyes. I end up just looking at him trying to think what it is he is trying to do." "Interacting with a child is an ordeal for me no matter what. I used to truly hate doing so. So I used to think being in the company of young people was so much better. But now, I've come to feel that I have to keep trying nevertheless, because it's my duty." "I can't recall any happy times with my mother. I don't remember being held by my mother. I used to be daddy's girl. My parents were always fighting, and I hated approaching them. So being alone was all right; it meant nothing to me ...", thus recounting her childhood, overlapping the images with her own child-rearing (session 27).

Accompanying progress in these interviews of the mother, and continuing play between mother and child in the interview room, the mother gradually became capable of appreciating the changes in her child, to the extent of voluntarily stating

her son's increased understanding of the spoken word. "Y seems to understand things better than before. Taking the initiative in speaking to the child is still rare, but when I do, he does try to imitate what I say" (session 31).

When Y gestured that he wanted to be spun around in a chair, the mother made the uncustomary move of becoming actively involved, spinning the chair for him on her own volition and even emitting vocal markers such as "Yea!" and "Round you go!". In response to the author's high estimation and encouragement of her behavior, "You have made great improvement. You were conveying well that you were having fun, too. Y was having a great time with you. Until now, I could see a part of you disliking what you were doing", she replied, "It has become a lot easier for me. I think I am starting to understand what this child wants from me. That he understands a lot of what I am saying has been a great help. Now, I don't have to spend all my time thinking and worrying. I've come to realize that brooding on things won't make things better..." "I now see that I hadn't really been doing anything when I was dealing with him. I keep telling myself that I have to do something for him, that I must talk to him", thus relating that she was starting to get some grasp of how she ought to be interacting with her child (session 32).

Stage 6 : The mother's individualization and restoration of empathy (sessions 35 ~39)

Y's interests shifted to manipulating objects, and his demands towards his mother became more clear, but the mother was becoming increasingly capable of following through appropriately (session 35). Stating, "My relationship with my own mother used to be one of fear, but that has become better too. I'm now able to speak with her, which is a large improvement", she related with confidence how she was now able to fully embrace her child on one hand, while on the other, she was no longer intimidated by her own mother (session 36).

Looking back over the course of therapy, she reflected upon her own progress saying, "At the start of therapy, I used to think 'Since this is what I believe, my child has to be that way too', which made me irritable, and I was scolding him all the time." She had improved to the point of being able to say, "But now, I think 'I shouldn't speak to him in this way', or 'He must hate my talking to him this way'".

Mother-child interaction was becoming natural as never before, so that for example, when Y was having trouble drawing a circle with a pen, she would immediately step in, taking his hand in her own (session 39).

Stage 7 : The child's maturation and broadening of relationships (sessions 40~43)

Soon thereafter, dramatic transformation was seen (session 40). Y began talking to his mother copiously. Invited to play with a paper airplane by a nurse, he responded with delight. Riding piggy-back on his mother at his request, he focused on the plane in flight with outright curiosity, expressing joy with his whole body. He repeatedly clambered to the ground to pick up the fallen plane, would take it to the nurse, and climb back up on his mother's back. Encouraged by the nurse to give it a try, "Come here. Try it", he flew the plane himself, and was thrilled. The mother,

the nurse, and the author found ourselves clapping and cheering, and the interview room was momentarily transformed into a fun-filled playroom.

The mother noted, "As a child, I had never done anything on purpose just to give my mother a difficult time. This child does. So I end up being harsh with him. Despite efforts at moderation, my demands are still high. Because my ideals are high, I end up seeing things as hopeless ... but then, it is also true that my child is becoming different, compared to before", actively self-evaluating herself and her child.

In this manner, with steady progress of mother-child interaction in a favorable direction thus confirmed, and given the author's move to a different institution, therapy was concluded with this 43rd session. Therapy spanned one year and six months. Training and care of the child was thereafter entrusted to a welfare center.

5. The mother's history of eating disorder

The author investigated the treatment records of the mother's eating disorder judging that bringing factual data into light was indispensable for discussing the difficulties mothers with past eating disorders experience in child rearing. As a result, the following became clear. Incidentally, consent to conducting this investigation was obtained from the mother herself during therapy.

The mother grew up in a family of four including her parents and an elder brother 3 years her senior. At 18, she was enrolled in a science department of a national university. Her weight at the time was 42 kg. In her sophomore year, she left home to enter a girl's dorm, where she started cooking for herself. As she started getting back to the dorm at increasingly later hours, she started skipping meals and losing weight, to the point of dietary amenorrhea. In the third trimester of her sophomore year, her weight fell to 36 kg. Examination at an internal medicine clinic of a university hospital revealed no abnormalities. Moving out of the dorm, she resumed commuting to school from home, where she started taking regular meals, although in small quantities. However, because her weight did not return to normal, she came to receive treatment on an out-patient basis at a university hospital psycho-internal medicine clinic for anorexia nervosa. However, her condition showed little improvement, and becoming growing reticent, she took to falling silent and withdrawing to the privacy of her own room when coaxed by her mother to eat. For this reason, she was hospitalized and prescribed behavior restriction therapy. She was 151.7 cm in height and weighed 30 kg upon hospitalization. Laxative abuse and deliberate vomiting were not seen, nor was any conscious wishes for thinness evident. Response to therapy under hospitalization was good, and although pseudologia was noted part way through, indications for rapid recovery were seen once she became capable of relating her own feelings in interviews with the physician in charge. In-patient therapy continued for approximately four-and-a-half months. Her weight returned to 35 kg at discharge. Subsequently, she completed college and found employment. A few years later, she met and married her present husband through a friend.

Discussion

1. Child-rearing behavior by mothers with eating disorders and their psychopathological characteristics

A review of follow-up studies on women with past eating disorders reveal that the number of such subjects who experience marriage and child-birth subsequent to therapy are far from rare. Brinch Isager & Tolstrup (1988) report that although such women appear to have reduced reproductive capacities, that the percentage of women who are unable to have children does not differ significantly from that among the normal population. However, it is also known that such women encounter many difficulties in the face of actual child rearing (Woodside & Shekter-Wofson, 1990). And although there have been many studies regarding the problems surrounding child-birth by women with histories of eating disorders, detailed analyses in relation to child-rearing behavior are rare (Chatoor et al., 1987 ; Humphrey, 1989 ; Stein et al., 1994). Stein, Woolley, Cooper, & Fairburn (1994) report that observations of rearing behavior by women with past eating disorders revealed that expression of negative feelings were more frequent among such women in child-rearing during meal times in comparison to controls, and that they were more invasive toward their children. However, they also reported no difference between the two groups in situations of play.

In this report, we present the characteristics of how the psychopathology of eating disorders can be reflected upon child-rearing behavior through some concrete examples.

1) Difficulties in forming attachment

From the early stages of therapy to the very end, establishment of attachment between mother and child—a principal objective of the therapy—proved to be highly difficult. A major characteristic of this problem lay in the difficulties the mother had in accepting the child's desire for attachment with empathy. As epitomized succinctly by the difficulties she had in physically holding her child, the background to this was the mother's strong pessimism in capturing her child's rapidly emerging expressions of attachment brought about through therapy, not as something favorable, but as proof of his being as yet so infantile.

2) Inability to engage in play involving arousal of physical sensations or emotions

Inability to enjoy play on the sensory-motor level with the child despite the child's insistent demands. Inability to respond to her child's mischievous clinging in kind ; in fact, even feeling disgust at such behavior. For these reasons, the mother's play was not accompanied by fluctuations in emotion, rendering the actions passive in nature, lacking in vitality. This condition was well-portrayed by the mother's sincere worries that her son might not return to normal once he lost control, becoming totally immersed in play. This points to the extent of pathology on the sensory-motor level, which can be associated with the claim that cognitive disturbance on the sensory-motor level exists in subjects exhibiting eating disorders (Bruch, 1973). In any case, that the disturbance can appear in this form in child-rearing by a mother with past eating disorder may be considered valid rationale for taking this aspect into account

in considering support for child-rearing by such subjects.

On the other hand, the mother's doubts were immediately assuaged when the child started taking interest in drawing and writing towards the end of therapy, and she started displaying an active but relaxed form of interaction with her child, which was in sharp contrast with her previous uncertainty. When play on the sensory-motor level was replaced by a more intellectual form of play strongly characterized by learning, the mother was able to clearly enjoy sharing in such activities. This was also taken as further indication of the mother's cognitive disturbance on the sensory-motor level.

3) Approaches subverting growth of the buds of development

The mother's despair upon seeing the infantile antics of her child strongly pointed to her high level of demand and the existence of high ego ideals, making her almost compulsively demand the impossible of her child, constantly conscious of the eyes of others. For that reason, she was unable to approach her child in ways which would nourish the buds of self-expression, and underestimating the significance of such beginnings, had effectively been picking such buds as they sprang. It is seen that the mother herself not having been reared in ways conducive to activeness or independence was reflected strongly in this situation.

4) Inability to enjoy the moment due to high ego ideals

Due to the aforementioned high ego ideals, the mother placed ever-higher demands upon her child almost to the point of obsession, which was characterized by inability to enjoy sharing the moment with her child. The fact that the mother had always been conscious of her own mother's eye, behaving with how she would be evaluated constantly at the front of her mind is probably relevant as the backdrop to such pathology. In other words, it is believed that accumulation of the mother's own experience of not having been able to share and enjoy the moment with her own mother is being reflected heavily upon the pathology of the current mother-child relationship.

2. Child-rearing support for women with histories of eating disorders

The therapy described in this paper started as developmental support for the child, although it also took the form of active psychotherapy for the psychopathology of the mother herself. This is exactly the type of situation which gives greatest significance to mother-infant psychotherapy, and the results provide important suggestions for designing child-rearing support for women with past eating disorders.

In the process of psychotherapy, freeing the mother of maternal restraints was a principal theme, but at the same time, the author continued providing support for promoting mother-child interaction. A point which became particularly defined in the process was the mother's own developmental pathology surrounding acquisition of body image. Even with considerable deepening of insight, active development of mother-child interaction was not readily achieved, and the mother frequently fell into despair witnessing the infantile behavior of her son. However, as the mother became capable of discerning the intentions and feelings of her child through the

process of mother-child interaction, she gradually became capable of emotional interaction through play. Perhaps it can be said that actual realization of such change alongside the interviews led to the promotion of true insight.

Thinking along this line, it is believed that incorporation of therapeutic intervention for the mother's own pathology regarding body image was a vital point in the child-rearing support. In order to enable the subject to experience a deepening in relationships at the deepest level of interpersonal relationships, awakening the mother's own healthy physical sensations was of utmost importance, without which the foundations of an environment conducive to promoting sound ego development in the child could not be formed. This is also exactly the point we have been trying to convey in propounding the significance of affective communication (Kobayashi, 2000).

3. The psychopathology of eating disorders and intergenerational transmission

The issue of intergenerational transmission, i.e. transmission of the parents' psychopathology to the next generation, has become a much discussed topic accompanying mounting interest in preventive psychiatry (Earls, 1987 ; Rutter, 1989 ; Rutter & Quinton, 1984). In particular, this aspect has taken on grave significance in terms of child (Zeanah & Zeanah, 1989).

However, a point of note is that the phenomena of intergenerational transmission does not necessary imply direct transmission of the parents' morbid behavior (symptoms) (Oliver, 1993). Andrews, Brown & Creasey (1990) maintain that it is not the symptoms of the parents per se, but rather the negative experience of being detested or abandoned by the parents which are strongly associated with onset of psychiatric disturbances in children. This implies that the significance lies in the quality of attachment between parent and child. In reality, attempts at preventing intergenerational transmission of unstable attachment behavior between mother and child is being undertaken actively in mother-child therapy focusing upon attachment behavior (Van IJzendoorn, Juffer & Duyvesteyn, 1995). Such attempts can largely be divided into mother-child therapy focusing upon heightening the mother's sensitivity towards children's behavior, and those aiming at therapeutic manipulation of the internal representation of attachment behavior in the mothers themselves.

In the case presented in this paper, focus was first turned upon the problems regarding quality of child-rearing behavior noted in the mother, while the mother's internal representation forming the backdrop to her behavior was also taken up actively in the course of therapy. Thus focusing upon both aspects allowed for the clear emergence of how the psychopathology of a mother with a history of eating disorder was reflected in her child-rearing behavior, and how that behavior was associated with her internal representations.

The mother's unstable attachment to her own mother in the past was being reflected in various forms in the present relationship between herself and her son. A point of particular note lay in the fact that the mother responded not with joy but even disgust to the attachment behavior expressed by her son towards herself. In light of her own values determined by past experience, the act of showing attachment

towards parents was unacceptable.

It is well known that eating disorder patients invariably hold extremely high ego ideals, which together with obsessive-compulsive tendencies give rise to various pathological behavior. The case under discussion is no exception, and the relational pathology between mother and child arose from the mother's abnormally high ego ideals which made it difficult for her to accept her child as he was. In other words, the mother was unable to capture her child as he was at any specific moment, always negating reality in pursuit of ideals. Within her world of internal representation, the image this particular mother held of children was that of little people who were capable of doing everything for themselves with little attachment to the parents, which was an image formed through her own mother-child experiences in infancy. The point of interest was that when the mother became capable of even just marginally accepting her child as he was following alteration of her values through therapeutic intervention, attachment behavior between mother and child underwent rapid transformation.

As shown above, the mother in this case had a history of eating disorder, and it was indicated that problems in attachment with her own mother was being reflected heavily in the quality of attachment between herself and her son. In this instance of intergenerational transmission, the relationship disturbance between mother and son was improved through promotion of attachment formation between the two, which also had a beneficial effect upon the child's development.

It is necessary to take into account the fact that the child in this case harbored a developmental disturbance as a factor giving rise to the early manifestation of relational pathology. It is easy to see that accepting the reality of a son exhibiting clear delay in development was no simple task for the mother with inappropriately high ego ideals. This is also apparent through the transition seen in mother-child interaction, from awkward to one of great composure, the moment the child turned from physical-sensation oriented play to a more creative form of play, which in this case was drawing.

However, as increasing numbers of subjects with eating disorders recover and go on to become parents, awareness of the possibility of intergenerational transmission should provide a valuable perspective in planning support, even in the absence of vulnerability on the part of the child.

References

Andrews, B., Brown, G. W. & Creasey, L. (1990): Intergenerational links between psychiatric disorder in mothers and daughters : The role of parenting experiences. *Journal of Child and Psychology and Psychiatry*, **31**, 1115-1129.

Brinch, M., Isager, T. & Tolstrup, K. (1988): Anorexia nervosa and motherhood : Reproduction pattern and mothering behaviour of 50 women. *Acta Psychiatrica Scandinavica*, **77**, 611-617.

Bruch, H. (1962): Perceptual and conceptual disturbances in anorexia nervosa. *Psychosomatic Medicine*, **24**, 187-194.

Chatoor, I., Egan, J., Getson, P. et al. (1987): Mother-infant interactions on infantile anorexia nervosa. *Journal of the American Academy of Child and Adolescent Psychiatry*, **27**, 535-540.

Earls, F. (1987): On the familial transmission of child psychiatric disorder. *Journal of Child and Psychology and Psychiatry*, **28**, 791-802.

Fukamachi, T. (1987): *Therapy of eating disorders*. Tokyo : Kongo Shuppan (in Japanese).

Humphrey, L. L. (1989): Observed family interactions among subtypes of eating disorders using structural analysis of social behaviour. *Journal of Consulting and Clinical Psychology*, **57**, 206-214.

Kobayashi, R. (2000): Affective communication of infants with autistic spectrum disorders and internal representation of their mothers. *Psychiatry and Clinical Neurosciences*, **54**, 235-243.

Kobayashi, R., Shira'ishi, M., Ishigaki, C. et al. (1997): Activities of mother-infant unit in Tokai University School of Health Sciences. *Japanese Journal of Medical and Psychological Study of Infants*, **6**, 31-43 (in Japanese with English abstract).

Newson, J. (1978): Dialogue and development. In A. Lock (Ed.), *Action, gesture, and symbol* (pp. 31-42), New York : Academic Press.

Oliver, J. E. (1993): Intergenerational transmission of child abuse : Rates, research, and clinical implications. *American Journal of Psychiatry*, **150**, 1315-1324.

Richer, J. M. (1993): Avoidance behavior, attachment and motivational conflict. *Early Child Development and Care*, **96**, 7-18.

Rutter, M. (1989): Pathways from childhood to adult life. *Journal of Child Psychology and Psychiatry*, **30**, 23-51.

Rutter, M. & Quinton, R. (1984): Long-term follow-up of women institutionalized in childhood : Factors promoting good functioning in adulthood. *British Journal of Developmental Psychology*, **2**, 191-204.

Sameroff, J. & Emde, R. (Eds.) (1989): *Relationship disturbances in early infancy*. New York : Times Books.

Stein, A., Woolley, H., Cooper, S.D. et al. (1994): An observational study of mothers with eating disorders and their infants. *Journal of Child Psychology and Psychiatry*, **35**, 773-748.

Tolstrup, K., Brinch, T., Isager, S. et al. (1985): Long-term outcome of 151 cases of anorexia nervosa : The Copenhagen anorexia nervosa follow-up study. *Acta Psychiatrica Scandinavica*, **71**, 380-387.

van IJzendoorn, M. H., Juffer, F. & Duyvesteyn, M. G. C. (1995): Breaking the intergenerational cycle of insecure attachment : A review of the effects of attachment-based interventions on maternal sensitivity and infant security. *Journal of Child Psychology and Psychiatry*, **36**, 225-248.

Woodside, D. & Shekter-Wofson, L. (1990): Parenting by patients with anorexia nervosa and bulimia nervosa. *International Journal of Eating Disorders*, **9**, 303-309.

Zeanah, C. H. & Zeanah, P. D. (1989): Intergenerational transmission of maltreatment : Insights from attachment theory and research. *Psychiatry*, **52**, 177-196.