Love is not Enough... The Need for Adapted Parenting

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Abstract
Parental maltreatment due to inadequacy is a form of inappropriate parenting that leads to emotional, educational, and/or neglect-related deficiencies with severe consequences for a child's physical and psychological development, though it is not necessarily intentional abuse. This constitutes a violation of the fundamental rights established in the United Nations Convention on the Rights of the Child.

We present the case of a two-and-a-half-year-old boy who was brought to the emergency department by the police. He was severely malnourished, which resulted in nutritional rickets and developmental delay. He had been fed almost exclusively breast milk. His parents had a profoundly distorted perception of his needs. This case is discussed from paediatric, child psychiatric, and legal perspectives.

Introduction

Rickets, a growth disorder caused by severe nutritional deficiencies, is still observed in industrialized countries and serves as a warning sign of serious deficiencies in the care of a child (1).

When these deficiencies result from parental maltreatment due to inadequacy, the situation becomes even more concerning, as it involves neglect of the child's fundamental needs. Though often unintentional, this form of maltreatment has devastating physical and psychological consequences, that jeopardize the child's overall development. According to the United Nations Convention on the Rights of the Child (UNCRC), every child has the right to adequate nutrition and medical care, and to an environment that fosters their well-being (2). Failure to meet these basic needs can result in developmental delays, cognitive and emotional impairments, and long-term health issues.

This article explores the connections between inadequate parenting, parental psychiatric disorders, attachment issues, rickets, and violations children's rights, emphasizing the need for collective vigilance to safeguard vulnerable children.

Clinical Case

In late August 2024, a 2.5-year-old boy, was brought to the emergency department by the police due to suspected malnutrition. He had been reported to child protection services by maternal family members. Following an initial evaluation, the juvenile court ordered emergency protective custody.

The boy was an only child was living with his parents. He had irregular medical follow-ups with different doctors from the age of 6 months old, and there were no consultations between the ages of15 months and 2.5 years. He had only received the polio vaccination (the only mandatory vaccine in Belgium), and his parents chose, not to offer vitamin D supplementation from birth, despite medical advice. At admission, the boy's weight was below the third percentile (Gomez classification < 60%), indicating severe protein-energy malnutrition. His growth curve showed a marked decline starting at six month. He had been on an exclusively milk-based diet since 20 months of age and had a complete food aversion.

Clinical evaluation revealed signs of severe malnutrition, including pallor, rickets, and skeletal deformities such as genu varum, bowed femurs, and wrist deformities. Laboratory tests indicated iron deficiency anaemia (Hb: 6.2 g/dL [N 12.0]), severe vitamin D deficiency (5 ng/mL [N > 20]), and severe hypophosphatemia (0.55 mmol/L [N 1.00-1.95]), responsible for severe rickets confirmed by radiographs of the leg, knee, wrist, and pelvis. Secondary hyperparathyroidism was also present, with elevated alkaline phosphatase levels (3.094 U/L [N 100-320]), indicating increased bone remodelling.

Developmentally, he exhibited motor delay (walking acquired at 21 months) and limited language skills, still presenting jargon at the age of 30 months.

His immediate medical management included nasogastric feeding with a whey-based extensively hydrolysed formula, iron, vitamin D, and phosphate supplementation, alongside gradual introduction of meals outside his hospital room without parental presence. Child psychiatric intervention was initiated in a day hospital setting while staying in the paediatric hospitalisation unit at night. He presented as severely withdrawn and absorbed in his own world. He responded only with fixed smiles and exhibited repetitive and stereotyped movements. He also used very few words.

The parents displayed a partly involuntary non-compliance with medical recommendations, particularly with regard to dietary diversification from six months of age onwards. Continuing exclusive breastfeeding was not their deliberate choice. After an initial introduction of spoon-feeding and solid foods at around 12 months of age, they were unable to manage his progressive

and then absolute refusal to diversify his diet. They reported not realising the profound impact of this regression on his physical and psychological health and development.

Despite demonstrating affection and concern for their son's well-being after five months of hospitalisation (child psychiatric day care and paediatric night care), the parents continued to deny their role in his severe health condition. Their ongoing questioning of paediatric and psychiatric interventions and their lack of collaboration further delayed the child's progress and full recovery. Parental and family interventions proved ineffective, as discussions were limited to interrogating the medical team and pointing out its inefficacy in getting the child to eat. Due to the parents' persistent hampering of the treatment and their lack of adjustment to the child's health and developmental needs, the healthcare team sought judicial intervention to limit parental presence, particularly at night.

Since these protective measures were implemented by the juvenile court, the child has shown significant progress in domains of motor skills, language, emotional and relational skills. He now shows signs of developing an emerging, individualised sense of self, with increasing engagement with others, some playfulness and shared pleasure (3, 4).

Nutritional therapy has addressed deficiencies, yet feeding remains a therapeutic challenge as the boy continues to refuse to consume solid foods orally. A multidisciplinary approach is essential to support his motor, linguistic, emotional, and social development, as well as addressing legal considerations, and requires continuous adjustments. This treatment still needs to be administered in day and night hospitalization since his parents are unable to provide good enough medical and psycho-educational care to the child outside his day care hours.

Discussion

Child abuse manifests in various forms, including physical, psychological, and sexual abuse, as well as neglect. The mission of the SOS Enfants teams is to prevent and deal with situations of child abuse. These teams are skilled in understanding problematic situations and supporting families. They intervene in situations involving physical, psychological, sexual or institutional abuse, as well as situations of risk or neglect. According to data from SOS Enfants in 2021, 26% of calls received concerned physical and 26% concerned sexual abuse, while 19% concerned psychological abuse. 17% of calls involved children exposed to repeated domestic violence and nearly 12% concerned severe neglect (5).

Parental inadequacy as a form of child maltreatment in young children is characterised by a failure of parents or legal guardians to meet the child's fundamental needs. Although often unintentional, this form of maltreatment has severe consequences for the child's physical and psychological development and constitutes a violation of their fundamental rights as established by the United Nations Convention on the Rights of the Child (UNCRC) (6).

In this clinical case, the lack of age-appropriate cognitive and motor stimulation resulted in intellectual and psychomotor developmental delays (e.g., poor language acquisition), thus violating the child's right to education (Article 28 of the UNCRC). An inadequate and insufficient diet resulted in nutritional deficiencies and rickets, breaching the right to health and adequate nutrition (Article 24 of the UNCRC). A lack of medical care (only six medical visits in three years, fragmented follow-up by three different paediatricians and incomplete vaccinations) compromised the child's right to proper healthcare (Article 24 of the UNCRC). Finally, the absence of social interactions (no schooling, an isolated home environment, and difficulties forming relationships) restricted the child's right to socialisation and personal development (Article 31 of the UNCRC).

His parents lived in an isolated nuclear family unit and did not seek advice or help from professionals or relatives regarding their son's feeding difficulties. Their vulnerabilities regarding attachment and personality appear to have resulted in a lack of epistemic trust (7). They relied exclusively on their own beliefs and convictions about nutrition and child-rearing. This beliefs were neither widely shared nor validated by society, and were medically and psychologically harmful.

Moreover, the parents had a distorted perception and interpretation of their child, his intentions, and his needs. Fonagy termed their "tendency to elaborate models of internal states in the absence of relevant evidence" as "hypermentalising", and more specifically "intrusive pseudo-mentalising" (7). They harboured an idealised view of their child believing him to be highly intelligent and having the maturity to make independent choices about his nutrition, clothing, and screen time. The parents insisted that his lack of verbal communication was a deliberate decision on his part; not due to developmental delay. They firmly believed that their child could self-regulate and self-sustain without external intervention, and that parent-child interactions should be courteous and conflict-free.

We hypothesise that the emergence of their son's subjective self between the ages of 7 and 15 months was intolerable for his parents (3). Until the judicial authorities intervened, the child existed in a symbiotic fusion with his mother, without a transitional space, thus preventing the separation and individuation processes necessary for psychological birth (4, 8) When confronted with their son's emerging autonomy and independent desires, the parents were unable to adopt a mature mentalising stance and failed to engage in healthy negotiations around his needs. Instead, they unconsciously resorted to denial of their child's individuality and induced a regression to an oral-symbiotic phase, reinforcing a mother-child fusion through prolonged exclusive breastfeeding.

At the child psychiatric day hospital, parental intervention and engagement in therapy remains unfeasible. The parents continued to deny their role in and responsibility for their child's condition. During parental consultations, they failed to engage in mentalising their difficulties in their relationship with their son and refused to engage in therapeutic reflection. It appears narcissistically unbearable for them to acknowledge their shortcomings and to accept that medical professionals might be more competent in feeding and nurturing their son than they were. Consequently, on an unconscious level, they may have signalled to their son that accepting food from us posed a vital risk to his psychological stability. The only intervention the parents valued was the parent-child interaction workshops, where, through play and movement, we worked to enhance parent-child interactions, help parents interpret their son's meaningful expressions, and guide parents in adjusting to their child's psychological movements.

Some reflections for therapeutic support

As clinicians, we should be aware of relational knots, dead ends and "pathways" that the family systems can create to circumvent the therapeutic process. It is certainly a clinical risk, primarily for the children involved. Traumatized, the boy had to alienate part of himself to exist, to feel somewhat loved. Professionals can also be threatened with wanting to "act quickly and well," not respecting enough the child's rhythm, forcing individual and relational dynamics, blinding themselves as the process reaches its limits and generates a "secondary trauma". The professional posture is so solicited, engaged, that we allow ourselves to call it, in a metaphorical way, "therapeutic funambulism". By funambulism, we must understand the ability, the virtuosity allowing us to play around with difficulties, to be able to determine the solutions. By this term, we emphasise the multidirectional caring attitude that must be adopted even if our primary patient is the child. The

balance must constantly be found between questions, support, connotation, reframing, ... and stopping, if necessary (9).

To adequately accompany the family, we favour a logic of network intervention that is based on the work of medical, psycho-social and legal gridding. The mesh can be understood as a system that contains, assists, monitors and cares, the first level of which certainly concerns child protection, from the onset of the intervention. There may indeed be a real, current and serious danger to the child. Not so much the incapacities of the adult, but rather the detrimental effects of his functioning on the child, sometimes necessitates a distancing from the child. Some, however, advocate maintaining contacts in a supervised setting to respect filial loyalty and connection. The term "mesh" illustrates the intersection of help and care in several directions. Each link in the mesh represents a point of contact, a meeting. The mesh is gradually built , with its weft evolving, tightening or relaxing depending on the risks and on the evolution of the postures of each person involved. Multi-stakeholder intervention also enhances the chances of building trust with the protagonists in complex settings such as high parental conflicts, situations where there is a risk of loss of parental bonds, in which the relational dynamics are based on the complementarity of the rigid type with abrupt oscillations between fusion and rejection.

In the light of these considerations, it seems important to grant an actual place to the adult who is speaking to the professional about his child. It is a matter of welcoming and accompanying this parent, by offering him an adjusted listening, of allowing him to speak, of trying to join him in what he says, in what he expresses about his child. This caring professional attitude, which aims to help and care by ensuring the right amount of protection and respect for integrity, requires to be comfortable with the "funambulism" mentioned above. Understanding without judgement is the first step in any intervention. The prospect of relevant support for the parent, the child and the family requires, in advance, the most accurate assessment possible of the relational context and the history of a family. To do this, it is an asset to intervene with several professionals or even with several services, so much so that the intersecting viewpoints are complementary in a respectful and adequate understanding.

A factor in the establishment of a significant network is mutual trust between services, a state of mind that contributes to the basic serenity conducive to high-quality collaborative work. Without a modicum of calm, rivalries and disqualifications would prevail. Trust can only be gained through continuous reflection on one's practice, a good knowledge of the status of the network, its evolution, the various services of which it is composed, and certainly through the maintenance of respectful interpersonal relationships. It is not a question of opting for single mode of thinking or of reinforcing each other's interpretations of the families, but rather of establishing platforms for discussion and reflection, fuelled by each other's specific work. No one can claim to "know" about a family's functioning by patronizing another person's opinion. We should intervene certainly with our emotions but mostly in terms of hypotheses by welcoming the opinion of others, possibly opposed to ours, as a complement of comprehension and observation, without necessarily seeing it as a disqualification of what we have understood. How many families show themselves differently from one place to another, depending on the interpersonal stakes of alliance and coalition? It should be noted that if a family displays a positive evolution, it is regularly attributed to the resources of the family system, whereas in the case of a negative change, the responsibilities are essentially placed on the professionals (10).

There are a number of factors that determine the operational dimension of a network. It is not a question of making mental and relational functioning more cumbersome by putting forward administrative frameworks and controlling attitudes, but rather of supporting creativity. It should be emphasized that trying to bring about change without respecting the time needed to understand the reasons for the modes of operation is to neglect each singular creation of a family and its multiple meanings. In the same way, it is necessary to know the context in which a network is set up, as well as the awareness of the network by its protagonists as a structure on itself.

In the same vein, let us be vigilant not to be alienated, nor to alienate colleagues in the "next door" service. Concretely, being alienated implies letting oneself think what the other wants us to think; in situations of child abuse, the prudence of experience teaches us the need to be authentic with ourselves, that is to say, to confront our elaboration with the real, avoiding being led to think in another way (11).

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Conclusion

This case illustrates a severe form of paediatric malnutrition, resulting in rickets and developmental delay, a rare occurrence in industrialized countries. It highlights the severe consequences that inadequate paediatric follow-up and dysfunctional parenting can have on a child's health.

This case underscores that love alone is not sufficient and that appearances can be misleading. As clinicians, we may be misled by loving parents whose behaviours is critically inappropriate for their child's fundamental needs. The case emphasises the need for heightened vigilance among healthcare professionals in cases of irregular consultations, symptom minimisation, or refusal of medical recommendations.

A proactive approach combining structured paediatric follow-up, early screening of family vulnerabilities, tailored communication, and parental guidance is essential to prevent similar cases (12). When necessary, reporting to child protection authorities is imperative.

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