Rejection and avoidance of food in a child of three years following a medical problem affecting the mouth: a proposal for clinical psychodynamic home intervention

Silvia Cimino & Luca Cerniglia

Recent literature has highlighted the lack of studies concerning possible clinical interventions in cases of early eating disorders. We will report the case of a three-year-old girl who refuses and avoids food as a result of a medical problem affecting the mouth. Through the presentation of the various stages of assessment and intervention, the aim of this paper is to contribute to the development of verifiable and empirically based treatment, introducing innovative clinical work, which includes psychodynamic home intervention for the child. By means of empirical tools given to the parents to assess the psychopathological profile of the mother, the father and the child, and thanks to the use of observational procedures to highlight the features of feeding interaction, the paper aims to focus specifically on the appearance of this particular eating disorder and the need for all-round care of the child and her welfare, including targeted clinical interventions and specific treatment at home for the child. Conclusions: We believe that by providing a specific diagnosis, a subsequent clinical intervention to support the entire family unit can be worked out. In particular, it has been possible to reactivate a process of development that seemed to have stopped at the stage of weaning.

Introduction

The most recent studies highlight the scarcity of publications concerning possible clinical interventions in situations of early eating disorders, stressing the need to develop therapeutic strategies that are verifiable and empirically based (McGrath Davis, Bruce, Cocjin, Mousa, Hyman, 2010). In particular, little attention has been given to situations in which the child's eating disorder persists even after the removal of an organic problem connected to the oral and/or gastric sphere.

The pioneering work was started in the 80s by Kreisler and Cramer (Kreisler, 1985; Kreisler and Cramer, 1982), who attempted to develop an initial model of intervention for eating disorders in children, and this went on to the more recent contributions of Chatoor (2002) and Benoit (2000) who have tried to direct special clinical programs towards the specific characteristics of this disorder manifested in children. The proposals of Manzano, Palacio-Espasa (1993) and McDonough (2004) are also interesting. Both have researched into an innovative model of intervention, which is not yet fully systematized, using the technique of video-feedback.

Starting from the contributions of Chatoor and Benoit, the authors of this paper have developed an innovative intervention which, together with the attention focused on the need to consider very carefully the type of eating disorder in the child, has used the technique of home intervention, based on the large amount of literature concerning *Home Visiting* in cases of parental distress and the child’s developmental risk (Ammaniti, Speranza, Tambelli, Muscetta, Lucarelli, Vismara, Odorisio, Cimino, 2006). The studies in this field highlight how, in situations of intense distress both of the child and its care environment, it may be appropriate to provide a setting for home intervention, because it has been found that this specific form of support simplifies the therapeutic relationship between the clinician and the family (Sweet, Appelbaum, 2004).

Aims

In this clinical paper we report the case of a three-year-old girl who refuses and avoids food as a result of a medical problem affecting the mouth. Through diagnostic assessment and clinical intervention, the work sets out to focus on the specific eating disorder presented and the need for all-round care of the child in her surroundings, offering the innovation of home psychodynamic intervention for her. The project, in its various phases, was carried out at a Public Services Institution in Rome specialized in child development to which the family was sent by the pediatrician who is part of the working group and who reports the need for a deeper investigation and / or psychological intervention in such cases. The pediatrician was in constant touch with the team that followed this case, which was made up of a psychotherapist with specific training in child development, a clinical psychologist experienced in working with parents and in the administration and coding of empirical tools.

The case of C.

C.'s parents requested a consultation for their three-year-old daughter because of her stubborn refusal of solid foods. The consultation was carried out by a psychotherapist experienced in child development and the clinical assessment by means of empirical tools (*Symptom Checklist-90-R* (Derogatis, 1994); *Eating Attitude Test-40* (Garner, Garfinkel, 1979); *Child Behavior Checklist 1 ½-5* (Achenbach, Rescorla, 2000); *Scala di Valutazione dell'Interazione Alimentare* – S.V.I.A. (Lucarelli, Cimino, Perucchini, Speranza, Ammaniti, Ercolani, 2002); *Feeding Resistance Scale* (Chatoor, Ganiban, Harrison, Hirsch , 2001) was carried out by a specially trained psychologist. The little girl, after a very intense episode a few months previously of gastroenteritis with symptoms of violent and repeated vomiting, showed complete avoidance of solid food characterized by terror and intense resistance to bringing any liquid or solid substance near her mouth. During the consultation, the parents reported that C. was bottle-fed while half-asleep during the night, despite the fact that the medical problem had completely cleared up.

During weaning, the child showed refusal and negative behavior towards the new foods that she was offered and meals were characterized by extreme slowness and intrusiveness on the part of the parents. C. had never reached the stage of eating completely solid food by herself.

From the pediatric assessment, carried out approximately one month before the request for a psychological consultation, it emerged that C. showed symptoms of severe and chronic malnutrition (Kuczmarski, Ogden, Grummer-Strawn, Fegal, Guo, Mei, Curtin, Roche, Johnson, 2000) . There was no evidence of any organic causes linked to her failure to thrive.

A brief medical history

C. is the first and only daughter of an older professional couple. Both parents are very upset and concerned about the physical health of the little girl. They report that they have tried many ways of feeding their daughter, even forcing her to eat, but without success.

The little girl sleeps in the parents' room, and does not want to give up her dummy which she uses with great vigor. She has been in kindergarten for over six months and continues to show signs of intense distress when she has to be separated from her mother. C. is described by the parents as very active and lively, but still limited in her use of language.

Evaluation of the psychological behavior of the parents

Both parents were given the following assessment tools: a) *Symptom Checklist-90-R* (Derogatis, 1994); b) *Eating Attitude Test-40* (Garner, Garfinkel, 1979).

a) Both parents showed high scores, comparable to clinical samples (Ammaniti, Lucarelli, Cimino, D'Olimpio, Chatoor, 2011) in some subscales. Mother: *somatization* = 1.1, *obsession-compulsion* =1.4, *depression* = 1.37, *anxiety* = 0.9, Father: *hostility* = 0.9, *anxiety*=0.2, *phobic anxiety* = 1.

b) Neither parent exceeded the limit in the global score (Garner, Garfinkel, 1979). For the mother, there was a high score, comparable to clinical samples (Ammaniti et al., 2011; Cuzzolaro, Petrilli, 1988) in the subscale of *bulimia and worries over food* (5.8).

Evaluation and observation of the child

The parents were asked to fill out a) the *Child Behavior Checklist 1 ½-5* (Achenbach, Rescorla, 2000) and b) a video recording of the meal in the family home was carried out using the *Scala di Valutazione dell'Interazione Alimentare* – S.V.I.A. (Lucarelli et al., 2002) and the *Feeding Resistance Scale* (Chatoor et al., 2001).

a) High scores emerged, comparable to clinical samples (Ammaniti et al., 2011) in the subscales: *anxiety / depression* = 5.2, *somatic complaints*=6.3, *withdrawal* = 5.1, *aggressive behavior* = 11.6.

b) A video recording of a main meal was carried out by applying a) the *Scala di Valutazione dell'Interazione Alimentare* – S.V.I.A. (Lucarelli et al., 2002) and b) the *Feeding Resistance Scale* (Chatoor et al., 2001).

a) High scores, comparable to clinical samples, emerged (Ammaniti, Lucarelli, Cimino, D'Olimpio, Chatoor, 2010) at all points on the Scale: *emotional state of the mother* = 17.2, *interactive conflict*=13.6, *behavior of food refusal in the child* = 8.4, *the emotional state of the dyad* = 7.1.

b)High scores emerged, comparable to clinical samples on the scales: *pre-oral resistance II* =17 and *intra-oral resistance*=15.

The clinical work with the parents

The parents were offered weekly meetings as a couple, led by a psychologist experienced in working with parents, and these lasted for a period of six months. Subsequently, the mother started a course of individual psychotherapy with two sessions per week at a Public Service in her area of residence. After the first three meetings, given the difficulties of the parents in creating a good therapeutic alliance and the urgency of the situation of the child whose body weight was reaching the threshold for clinical attention, which was highlighted by the pediatrician in the team, home care intervention for C. was suggested. Despite initial suspicion, the parents agreed to this work being carried out for their daughter, commenting that they would not have agreed to "take her to a doctor's surgery". The work with the parents enabled both of them to take advantage of some time to think both about their parental role and also about their experiences as children with their own parents (Chatoor, 2002; Cooper, Whelan, Woolgar, Morrell, Murray, 2004). Thanks to their work as a couple, which allowed the father to become more involved in his parental role, the mother was able to make a plea for help for herself, recognizing her own personal difficulties about food, that had begun in her teens.

The clinical work with the child

The child was treated exclusively with psychodynamic clinical work at home twice a week for a period of eight months. The work was conducted by an experienced child psychotherapist. An approach to food was programmed, within a relationship geared towards mutual sharing. The child was told that a lady-doctor would come to her house to help her not to be afraid of eating any more and they would play together. C. was reassured about the fact that the doctor would not offer her any foods that she did not want to eat.

We can divide the treatment carried out into four phases: a) *the familiarization with the idea of food*; b) *the arousal of curiosity for food*; c) *the first approach of the food to the mouth*; d) *the experience of getting dirty and making a mess.*

a) *The familiarization with the idea of food*: at this stage it was possible to work with the child creating a stable and predictable situation where food could be managed. Initially, C. did not want to get involved at all with anything associated with meals. Every suggestion made by the parents was met with intense anxiety and rejection. By starting to involve the child directly in the choice of a place where she could consider having something to eat, little by little, a less terrifying space was created in which it was possible to proceed. The little girl agreed to approach the idea of food using a low table with a small chair.

Since any suggestions of food or drink other than milk and water offered in a bottle were rejected, it was suggested to the child to use toys as dishes, cups and small pots. Slowly, C. agreed to bring the toys onto the little table. It became possible to start a symbolic game in which C. prepared the food and offered it to the doctor. Subsequently, the child herself began to try the food she imagined to be on the toy dishes.

The fact that she could create a play environment concerning food, allowed C. to pretend to open her mouth and to imagine a food situation appropriate to her age.

After a few months’ work, the little girl suggested taking some food and drink from the kitchen and bringing them to the place she had prepared for the snack.

b) *The arousal of curiosity about food*: in this phase C. chose some food and drink with which to begin playing. Her first request concerned fruit juice and, at a later date, chocolate, cookies and candies.

Initially, some bottles containing the fruit juice were kept away from the table. C. looked at them and picked them up without opening them. Subsequently, the child began to use the liquid substances and pour them into the small toy cups. The decanting game allowed C. to touch the liquids with her hands.

After a few weeks, the little girl began to play with solid foods, choosing only chocolate, cookies and candy, seeing what it was like to touch these foods with her hands. Within a relational climate of mutual trust and care, the child was able to experience an ever- growing interest towards food substances.

At this stage, C. did not bring any kind of food towards her mouth, but she was beginning to become familiar with and manipulate just chocolate, cookies and candy in a game that allowed the creation of new and positive experiences that she did not perceive as dangerous.

c) *The first approach of food to the mouth*: in this phase the child spontaneously began to bring some liquids towards her mouth (fruit juice, using toy cups) and some solids (chocolate, cookies and candies, using her hands). After tasting these foods individually as well as the fruit juice, she began to mix them together. She brought tiny amounts of food and/ or liquid to her mouth in order to taste the flavors that she had produced by mixing the foods together. To begin with, C. reacted with disgust and always looked at the doctor after her attempts to taste the food. Thanks to a positive reaction, in which the doctor praised the efforts of the child and, when invited to do so by C., tasted some of the food, the little girl began to put larger quantities of solids and liquids into her mouth. We can assume that C. was able to experience a good reciprocal relationship with the doctor, that is, a dyadic synchronous exchange suited to her developmental needs, in the presence of an non-intrusive emotional support, in a situation where she could decide the timing and method of approach to different foods.

d) *The experience of getting dirty and making a mess*: in this phase of the intervention the child began to ask for different types of foods and to manipulate them, initially exploring with her hands and then with her mouth. C. used the food to mess around with her hands, mixing foods of different colors, textures and flavors. Through the experience of getting dirty, C. was able to get to know what food was through physical contact by using her own skills and at her own pace of exploration.

By means of the doctor's encouragement, the child went through an experimental phase in which different kinds of foods could be touched without fear and enjoyed in small quantities, using her hands to bring the food to her mouth. The experience of trying out different foods and being able to express in words her pleasure and/or disgust without triggering off reactions of fear and phobic terror proved to be considerable.

At this stage, in the presence of her parents too, the child began to approach different types of foods, to touch them and to bring small amounts to her mouth, initially without sitting down at the table, but deciding when and how to take small pieces of food that her parents had put on the edge of the table for her during meals. Subsequently, C. began to sit at the table during family dinners and to be able to have her own plate in front of her without showing anxiety, fear and immediate rejection. The little

girl started to accept taking some pieces of food from her own plate by herself with her hands, while remaining seated at the table during meals with her parents. C. did not accept to be spoon-fed by her parents as and when they wished , screaming at every attempt by the parents to feed her.

Probably, it was possible to reactivate a development process that seemed to have stopped at the stage of weaning. C. started to show interest in food because she could explore it and use it in a game.

Conclusions

The clinical case which has been reported, necessarily partial and incomplete, highlights a number of points which can be interesting to consider:

a) *The problem of the diagnosis and the planning of the next intervention*: the possibility of offering a specific diagnosis that allows the development of a further targeted clinical intervention is critical in order to support the family unit. In the case of C., the child's phobic anxiety and terror at the sight of food which were typical of an aversive reaction due to her painful and traumatizing organic experience, increased the intense concerns of the parents, making the food situation a daily experience that was impossible to deal with. In these situations, in which dysfunctional eating behavior has appeared that has stabilized as a result of a medical problem affecting the mouth, we believe it is essential to organize clinical work both with the parents and with the child, to lower the level of alarm in the family unit and to foster more adaptive relationships (Nicholls, Bryant-Waugh, 2009).

b) *The role of the emotional-behavioral functioning of the child*: considering the emotional characteristics of the child, signs of anxiety, depression, somatic problems and aggression appeared from the initial assessment. Of course, we do not know if these difficulties occurred before or after the refusal of food following the medical episode, but we can assume that C.'s individual characteristics are in line with the psychological behavior of the parents, particularly of the mother. Several studies have shown that mothers who manifest difficulties over their food and traits of psychopathological risk towards depression, test their parental competence in relation to how much and in what way their child eats, and represent a significant risk factor for the appearance in their children of the same emotional-adaptive difficulties (Chatoor, 2002; Hagekull, Bohlin, Rydell, 1997; Micali, Simonoff, Treasure, 2009). In the case of C. we are led to suppose that the child already presented an eating disorder before the medical problems, possibly linked to the psychopathological difficulties of the mother, that pervaded the relationship between mother and child right from the first months of life. It is therefore possible to speak of "maternal contagion or vicarious trauma" to understand better the complex clinical picture shown by C.

c) *The contribution of the psychological behavior of the parents*: naturally, as is clear from the clinical case presented, the psychological profile of both parents made the interactive dynamic very complex and, within this, the emotive alarm reaction of the whole family system seemed to be exacerbated and maintained by the individual characteristics of the parents, particularly of the mother. In fact, from the initial assessment, risk characteristics had emerged in the emotional behavior of both parents, characterized by high phobic anxiety and, in the specific case of the mother, depression,

somatization, and personal difficulties in regulating her own diet had been identified.

Some writers have speculated on the mechanism of intergenerational transmission, according to which the functions of care-giving, impaired by the parent's emotional difficulties, such as in situations of eating disorders, give rise to unpredictable, inconsistent and intrusive behavior during shared moments of interaction which are often associated with childhood disorders in emotional control and the regulation of feeding times (Ammaniti, Lucarelli, Cimino, D'Olimpio, 2004; Ammaniti et al., 2010; Zachrisson, Skarderud, 2010).

It is interesting to note the contribution of the father over the question of food (Atzaba-Poria, Meiri, Millikovsky, Barkai, Dunaevsky-Idan, Yerushalmi, 2010). In particular, the emotional state of C.'s father, characterized by symptoms of anxiety, seems not to allow the mother to manage the dynamics of the separation-individuation properly (Mahler, Pine, Bergman, 1975). We can assume that the father, with his own concerns about the physical health of his daughter, exasperated the intrusiveness of the mother during feeding and favored the continuation of intense anxiety at times of separation between mother and daughter, also shown by the child's difficulty at leaving her mother when taken to nursery school, which she attends regularly.

We believe it is interesting to add that the nursery school teachers attended some joint meetings both with the clinician who was treating the mother and father and with the one taking care of the little girl together with the parents and they were given guidelines to support the therapeutic work. In particular, it was suggested that the child be offered the same foods as her schoolmates, and not the food prepared by her mother that C. used to bring, leaving her free to try any of the foods she felt like, without being forced to do so. This suggestion changed the attitude of the teachers, who used to insist on spoon-feeding the child, which resulted only in a reaction of intense rejection. We can assume that the changes which occurred during the clinical work, allowed C. to begin to experiment with small amounts of food and liquids even at school.

Finally, we think that the teamwork carried out, which made use of several professional figures, might be a useful working model to be used in similar cases. In particular, we believe that the home visiting, which allowed the parents to accept a specific intervention on the child, can be a useful example of how to begin a course of treatment that takes charge of the whole family environment.

References

Achenbach, T. M., Rescorla, L.A. (2000)*. Manual for the ASEBA preschool forms and profile*. Burlington, VT: University of Vermont, Department of Psychiatry.

Atzaba-Poria, N., Meiri, G., Millikovsky, M., Barkai, A., Dunaevsky-Idan, M., Yerushalmi, B. (2010). Father-child and mother-child interaction in families with a child feeling disorder: the role of paternal involvement. *Infant Mental Health Journal*, *31* (6), 682-698.

Ammaniti, M., Lucarelli, L., Cimino, S., D'Olimpio, F. (2004). Transmission intergénérationelle: troubles alimentaires de l'enfance et psychopathologie maternelle. *Devenir*, *16* (3), 173-198.

Ammaniti, M., Speranza, A.M., Tambelli, R., Muscetta, S., Lucarelli, L., Vismara, L., Odorisio, F., Cimino,

S. (2006). A Prevention and Promotion Intervention Program in the field of mother-infant relationship. *Infant Mental Health Journal, 27* (1), 70-90.

Ammaniti, M., Lucarelli, L., Cimino, S., D'Olimpio, F., Chatoor, I. (2010). Maternal psychopathology and child risk factors in infantile anorexia. *International Journal of Eating Disorders, 43*, 233-240.

Ammaniti, M., Lucarelli, L., Cimino, S., D'Olimpio, F., Chatoor, I. (2012). Feeding disorders of infancy: a longitudinal study to middle childhood, *International Journal of Eating Disorders, 45* (2), pp. 272-280.

Benoit, D. (2000). Feeding disorders, failure to thrive, and obesity. In C. H. Zeanah (eds.), *Handbook of infant mental health.* New York-London: Guilford Press, pp. 339-352.

Bryant-Waugh, R., Markham, L., Kreipe, R. E., Wolsh B. T. (2010). Feeding and eating disorders in childhood. *International Journal of Eating Disorders, 43* (2), 98-111.

Chatoor, I. (2002). Feeding disorders in infants and toddlers: Diagnosis and treatment. *Child and Adolescent Psychiatric Clinics of North America*, *11,* 163-183.

Chatoor, I., Ganiban, J., Harrison, J., Hirsch, R. (2001). Observation of feeding in the diagnosis of posttraumatic disorder of infancy*. Journal of the American Academy of Child and Adolescent Psychiatry*, *40*, 595-602.

Cooper, P. J., Whelan, E., Woolgar, M., Morrell, J., Murray, L. (2004). Association between childhood feeding problems and maternal eating disorder: role of the family environment*. British Journal of Psychiatry*, *184*, 210-215.

Cuzzolaro, M., Petrilli, A. (1988). Validazione della versione italiana dell'EAT-40*. Psichiatria dell'Infanzia e dell'Adolescenza*, *55*, 209-217.

Derogatis, L. R. (1994). *SCL-90-R Symptom Checklist-90-R. Administration, scoring and procedures manual*. MNV, Minneapolis: National Computer Systems.

Garner, D. M., Garfinkel, P. E. (1979). The Eating Attitudes Test: an index of the symptoms of anorexia nervosa. *Pychological Medicine*, *9,* 273-279.

Hagekull, B., Bohlin, G., Rydell, A. (1997). Maternal Sensitivity, Infant Temperament and the Development of Early Feeding Problems. *Infant Mental Health Journal*, *18* (8), 92-106.

Kreisler, L. (1985). Conduites alimentaires déviantes du bébé : l'anorexie mentale, la rumination ou mérycisme, les vomissements psychogènes. In Lebovici S., Diatkine R., Soulé M., *Noveau traité de psichiatrie de l'enfant et de l'adolescent.* Paris: Quadrige.

Kreisler, L., Cramer, B. (1982). Le bébé du dèsordre. In T. B. Brazelton, B. Cramer, L. Kreisler, M. Soulè (edited by). *Psichiatrie du bébé*. Paris: Eshel.

Kuczmarski, R. J., Ogden, C. L., Grummer-Strawn, L. M., Fegal, K. M., Guo, S. S., Mei, Z., Curtin, L. R., Roche, A. F., Johnson, C. L. (2000). CDC growth charts: United States. *Advances Data*, *314*, 1-27.

Lucarelli, L., Cimino, S., Perucchini, P., Speranza, A. M., Ammaniti, M., Ercolani A. P. (2002). I disturbi alimentari nella prima infanzia: validazione di uno strumento osservativo dell'interazione madre-

bambino. *Infanzia e Adolescenza*, *2,* 113-124.

Mahler, M., Pine, F., Bergman, A. (1975). *The Psychological Birth of Human Infant Symbiosis and Individuation*. New York: Basic Books.

Manzano, J., Palacio-Espasa, F. (1993). *Las terapias en psiquiatria infantil y en psicopedagogía*. Barcelona: Ediciones Paidòs.

McDonough, S. C. (2004). Interaction guidance: promoting and nurturing the caregiving reltionship. In Sameroff A. J., McDonough S. C., Rosenblum K. L., *Treating parent-infant relationship problems: strategies of interventions*. New York: Guilford Press.

McGrath Davis, A., Bruce, A., Cocjin, J., Mousa, H., Hyman, P. (2010). Empirically supported treatments for feeding difficulties in young children. *Current Gastroenterology Reports*, *12* (3), 189-194.

Micali, N., Simonoff, E., Treasure, J. (2009). Infant feeding and weight in the first year of life in babies of women with eating disorders. *The Journal of Pediatrics*, *154* (1), 55-60.

Nicholls, D., Bryant-Waugh, R. (2009). Eating disorders of infancy and childhood: definition, symptomathology, epidemiology and comorbidity. *Child and Adolescent Psychiatric Clinics of North America*, *18* (1), 17-30.

Sweet MA, Appelbaum MI (2004). Is Home Visiting an effective strategy? A meta-analytic review of home visiting programs for families with young children. *Child Development*, 75, 5, 1235-1456.

Zachrisson, H.D., Skarderud, F. (2010). Feelings of insecurity: review of attachment and feeding disorders. *European Eating Disorder Review*, *18*, 97-106.

Published online: 30 December 2014

E-Journal of Psychotherapy Research