

EMOTIONAL ASPECTS IN FOOD AVERSION IN PEDIATRIC PATIENTS: INTERFACE BETWEEN SPEECH THERAPY AND PSYCHOLOGY

Vanessa Souza Gigoski de Miranda^{1 2}, Orcid: <http://orcid.org/0000-0002-3332-9975>
Katherine Flach¹, Orcid: <http://orcid.org/0000-0003-3274-8606>

Food is a complex process, which is learned and improved, depending on the physical conditions and the child's development, as well as their oral and sensory abilities to interpret and to interact with the food. This complex function involves not only the organic aspects of the child, but also emotions, motivation, social and family environmental context of the child and his caregiver (Junqueira, 2017a). One study noted that 30% of children with normal development can find some sort of challenge in this process (Kerzner et al., 2015), while among children who have developmental changes, 80% can be found with eating disorders (Williams, Witherspoon, Kavsak, Patterson, & Mcblain, 2006).

According to Junqueira (2017b), among the risk factors for the development of eating difficulties might be cited:

- Health conditions (acute and/or chronic): The child health has important aspects that reflect in his daily activities, such as meals. In order to live the food experience it is necessary to take into account the child well-being and his will to do so. Acute conditions of organic diseases as, for example, otitis and irritability caused by tooth eruption can affect the development of this learning phase related to feeding.

- Pathologies of gastrointestinal system: As well as the item mentioned above, the gastroesophageal diseases also present themselves as organic health conditions that need to be identified and dealt with, so that it is possible to prevent damage in children feeding process and they deserve special attention: a child with gastroesophageal reflux disease, for example, is a child in pain, nausea and vomiting. That is, he is a child who possibly internalized the feeding event linked to negative feelings.

- Food allergies: Some babies may have traumatic experiences with some food due to allergic reactions and, in addition, to a late start of positive oral experiences (until the clinical diagnosis of allergy or intolerance to certain food), factors that can also impact child feeding development. Allergy symptoms can make it difficult as both the introduction of the first complementary feeding as the acceptance of the change of food texture.

- Disorders of heart and respiratory systems: To ensure a safe food is required harmony and coordination between breathing and swallowing. In infants, with breathing difficulties, it is common that there is a lack of coordination during feeding then, babies opt preferably for breathing. Changes of cardiorespiratory parameters in infants with heart disease, for example, reduce interest in food, beyond these babies are very manipulated and show, in most cases, a history of hospital admissions and various procedures.

¹ Universidade Federal de Ciências da Saúde de Porto Alegre (UFCSA), Porto Alegre-RS, Brazil.

² E-mail: vanessa_gigoski@hotmail.com



2 Emotional in food aversion

- Inability or dysfunctions of oral motor system: The mouth is the baby's world center for its importance for survival, by providing him feeding. The baby uses his mouth for exploitation and learning of what is his and what comes from the external environment. All training and oral experiences lived with the objects that are taken to the oral cavity generate sensations that are registered and ensure, together with his development and neuromotor maturation, an excellent preparation for food introduction. Children with chewing difficulties can become selective, giving preference for pasty or liquid food.

- The sensory system integration changes: The sensory information is first received, interpreted and after answered through our physical senses (taste, smell, sight, etc.). Sensory Processing dysfunction is a diagnostic term describing situations in which individuals are unable to process effectively and integrated the sensory information from the environment. To eat, we use every physical sense, and when there is some difficulty in the discrimination, interpretation or modulation of sensory input, the child may present significant difficulties to learn how to eat and to relate to food. Many children with complaints of feeding difficulty have sensory challenges, and if it is not diagnosed early can cause, over time, a real chaos to feeding development of the child.

- Conflicting Emotions: Due to the importance that emotions have to cognitive processes, the food learning needs to be surrounded by situations related to safety, care and comfort. The child needs to experience the food, the preparation, the development of good experiences with the food from the family model, exchanges and interactions with primary caregivers during this time, so that the situation of eating is seen as a safe and nice experience. A child who is forced to eat, or even experiencing threats or bargains related to meals in exchange privileges, commonly is a child who has just reinforcing negative patterns before the time of feeding.

In the United States, a group of multidisciplinary approach to children with feeding difficulties, proposed by Crist and Napier Phillips in 2001, describes a biopsychosocial model, in which we understand the 'whole child' perspective. This perspective includes sensory, motor, behavioral, emotional, physical, organic and environmental areas, all of equal importance to the assessment, to the diagnosis and to the treatment of these children (Crist & Napier- Phillips, 2001). From the creation of this integrative model, the authors follow reinforcing the paradigm of an expanded concept to the ways in diagnosing and treating children with feeding disorders (Toomey & Ross, 2011; Morris & Klein, 2000).

In Brazil, despite the food difficulties have been identified for a long time when dealing with pediatric patients, there is a scenario of lack of studies and data on these patients. Currently, the incidence of swallowing disorders and feeding difficulties in children is increasing, mainly due to rising rates of survival of premature babies with low birth weight and complex clinical history, who passed by a variety of procedures and interventions (Lefton-Greif & Arvedson, 2007). Junqueira (2017b) proposes six premises for the treatment of children with food aversion: to identify and to treat organic causes, to educate their parents, emotional support to mothers, normal development for the sequence of emotional learning, to ensure skill and comfort when having food and playful strategies to bring food to the child's routine. All these premises reinforce the importance of the parental bond, attention and availability to the child. According to the author, from these factors the first signs of food aversion can be identified (Junqueira, 2017a).

In clinical practice, it is observed that many parents state to feel unprepared and anxious about the disorder in the child's feeding. However, it is known that this situation may take months or years to normalize and this context could reverberate throughout the family (Hewetson & Singh, 2009). In the first stage of a child's food, in most cases, breastfeeding will transcend the nutrition task: it depends and will be increased by the bond between the mother and the baby, by the quality of interaction between both, as well as the mother's ability to observe the signals given by the baby, among other factors.

Turning to the psychoanalytic concepts, Melanie Klein (1996) points out that the individuals from birth naturally seek relationships with each other, which at first glance, most of the time, will be the mother. Through the mother's breast (first representative of the mother as a whole for the baby) and their experiences with it, which can be either sometimes gratification or sometimes frustration, the baby opens his way of relating to the world. In this direction, Winnicott (2002) highlights that in addition to the nutrition task, breastfeeding carries particular importance for the interaction that takes place at this time: the skin-to-skin contact, exchange of glances, the scent perception, the mother's heartbeat, even if an artifice is used to facilitate the child's nutrition, such as a bottle. In turn, Müller, Marin and Donelli (2015) complement bringing the understanding that the time of breastfeeding is an experience dedicated to the mother-child relationship, while the introduction of complementary feeding could represent an obstacle, meaning a separation of this dyad. Thus, the introduction of complementary feeding can be felt as a breakdown of the relationship between the mother and the baby, and for this reason often imply an acceptance difficulty both the mother and baby.

Added to this scenario the expectations created by the mother regarding her baby. As Lebovici (1987), the 'imaginary baby', that is, the one that is 'product' of mental representations of the mother, built from her references about motherhood and her desire to become a mother, is different from that baby is born. In this sense, during pregnancy, mothers feel anxieties, fantasies and fears about her baby, as he still is an unknown being for her. This process is vitally important and is part of the formation of the bond between the mother and the baby, however, the baby's arrival will lead to the meeting of the mother with the 'real baby', that is, a baby who has his own characteristics, desires, capabilities and requirements. At this meeting, it is quite possible that the mother does not identify all the characteristics that she had imagined before and, consequently, some 'disappointment' in recognition the 'real baby' arises, which will require from her a time of elaborating process. It will be important that the mother has the opportunity of investing gradually in the relationship with the 'real baby', placing on him his desires, expectations and feelings, so she can progressively develop the loss of her 'imaginary baby' (Lebovici, 1987; Soulé, 1987). Among the enabling factors for mother's preparation process are the baby's health, the conditions of pregnancy and delivery and mother-infant interaction in the first months after birth (Soulé, 1987; Fleck & Piccinini, 2013).

Understanding these aspects related to mother and baby representational world is important because they can influence how the mother (and father) relates to and behave with the child, bringing consequences for the baby development (Stern, 1995). However, as Fleck & Piccinini (2013), there are situations such as prematurity cited by the authors, but we can also think for the cases of patients with food aversion, which contribute to a very

large confrontation between what was imagined and desired by mother to what is experienced in reality. One of the crucial points for the narrowing of the mother-child relationship and the reconciliation of the 'imaginary baby' with the 'real baby', according to the aforementioned authors, was the abandonment of professional intervention in the mother-infant's contact.

From the child's point of view, the formation of an organic symptom, such as food disgust or refusal, can also be understood as a baby's response due to his dissatisfaction in relation to the interaction with his mother. In cases where the cause is emotional, but the symptom is organic, we are talking about psycho functional symptoms in infants (Donelli, 2011; Feliciano & Souza, 2011). Among the most frequent psycho functional symptoms in early childhood are sleep, eating, digestive and gastric, respiratory, skin and behavior disorders (Batista-Pinto, 2004).

Be the etiology from organic or emotional background, it is known, however, that there are cases where dietary changes inevitably require health professionals' interventions for the child's rehabilitation. In this context, it should be considered a special attention to the entry way that the professional, or the chosen therapy will occur, for that the bonding process of mother-infant is not affected and so the resistance chances of this dual are reduced during the treatment course on food refusal.

As Winnicott (2002), the baby's development is the result of the relations established by him, especially with the mother and the environment. Thus, the clinical baby is unthinkable without the presence and inclusion of his caregiver and / or guardian. Therefore, it is essential, that the health professional can act aiming to provide the mother assimilation regarding to baby feeding care, strengthening her and empowering her to exercise the child's care even when the professional is absent. In this sense, a work focused on education, autonomy and mother's safety are of utmost importance. As highlighted by Silveira, Lunardi, Lunardi-Filho and Oliveira (2005), although it is possible to establish a therapeutic relationship between the patient and the professional team, the patient and her family relationship has a great significance to her recovery.

It is known that feeding a child carries high emotional charge for parents, especially for the mother, who is socially and culturally as primarily responsible for the child's growth and well-being (Gonçalves & Rodrigues, 1998; Müller et al., 2015). On the other hand, the mother herself has the belief that it is through her care the child will be better supported and so, even if she has the possibility to rely on assistance from other family members, she still believes that it would be best her company with the hospitalized children (Melo & Frizzo, 2017). Thus, in this context where the mother is extremely focused on child care, the support network and especially the baby father's support play an important role (Rapoport & Piccinini, 2011).

Mothers who can not feed their children often feel guilty and create expectations through beliefs and feelings that they can hinder the child's nutrition. Therefore, no approach related to treatment of children with feeding difficulties will be effective if mothers are not heard, understood and included in the process. The goal of health professionals who work in this area should be welcome, listen, validate the feelings involved and understand them as part of treatment. Understanding and the managing of emotions, beliefs and social

judgment may ultimately contribute to the success of treatment of children with food refusal (Junqueira, 2017a).

In psychosocial terms, the standard of infant feeding involves the effective participation of parents as educators, through family interactions and strategies used at meal time, as a tool in the development of children's eating behavior (Gillespie & Acterberg, 1989; Ramos & Stein, 2000). Coercive strategies may introduce negative interactions, as children who are pressured or coerced to eat, may lose interest in food, even the existence of a reward, resulting in an opposing response. Both the reward as coercion are strategies used by parents as a way of instrumental feeding (Birch, 1992; Capaldi, 1997). However, the use of strategies/punishment reinforcements, with food used instrumentally, do not offer good long-term results and may promote a negative action towards the child preference for food (Birch, Mcphee, Shoba, Steinberg, & Krehbiel, 1987).

It is also understood that to be possible to establish a healthy relationship between child and food, and a comfortable one between mother (caregiver) and the baby, it is necessary that health professionals consider the whole child. In this perspective, the feelings and emotions of the child before the food, as well as the conditions of this child familiar context, should be investigated and considered. The patient's support network regarding food aversion should be systematically strengthened, aiming at making parents an integral part of the treatment of children with feeding difficulties.

Thus, it is essential to think about interventions with caregivers of pediatric patients with feeding difficulties, especially to mothers, considering the importance of promoting spaces for emotional expression during the child's treatment, which will inevitably arise anxieties, insecurities and fears. The attention to the awaken feelings can contribute not only in the treatment of food aversion, but also to prevent other maladaptive symptoms that may appear behind the feeding difficulty (Müller et al., 2015).

Although it is known that the disease of a family member generates significant suffering in the family and that family support is essential for the treatment of children, there are only a few studies that emphasize the importance of investment in the care of the patient's family, as mentioned by Melo and Frizzo (2017) in their statements about this issue. In this sense, it is considered that the inclusion of psychological treatment can help the care process to children with food aversion as it seeks to promote the strengthening the family and / or primary caregiver of the child strategies, but also by offering a space for qualified listening to the feelings arouse in parents during the child's treatment. Still, psychoeducation strategies can be built attending both parents and the other professionals who are responsible by the food aversion treatment, aiming to technically contribute with the multidisciplinary team.

The role of the psychologist combined with the practice of a speech therapist aims to facilitate the communication among patient - family - health team for a more integrated care to the patient and his family. Psychology acts as fundamental support for a speech therapist, who need support for the rehabilitation of the child with an eating disorder and this family, often weakened. We believe that the rehabilitation of individuals with eating difficulties should not only be directed to only one professional, and not with task divisions among specialties. We must see and treat the individual as a whole, taking into account this particularities. Thus, it is considered essential the multidisciplinary work for positive results

in the treatment of food aversion and, in this sense, it is understood as essential the communication among the involved professionals concerning organic and emotional factors committed in this problematic issue.

References

- Batista-Pinto, E. (2004). Os sintomas psicofuncionais e as consultas terapêuticas pais/bebê. *Estudos de Psicologia, 9*(3), 451-457
- Birch, L. L. (1992). Children's preferences for high fat foods. *Nutrition Reviews, 50*(9), 249-255.
- Birch, L. L., Mcphee, L., Shoba, B. C., Steinberg, L., & Krehbiel, R. (1987). "Clean up your plate": effects of child feeding practices on the conditioning of meal size. *Learning and Motivation, 18*(3), 301-317.
- Capaldi, E. (1997). Introduction. In E. D. Capaldi. *Why we eat what we eat. The psychology of eating* (2a ed., p. 3-9). Washington, DC: APA.
- Crist, W., & Napier-Phillips, A. (2001). Mealtime behaviors of young children: a comparison of normative and clinical data. *Journal of Developmental & Behavioral Pediatrics, 22* (5), 279-286.
- Donelli, T. M. S. (2011). Considerações sobre a clínica psicológica com bebês que experimentaram internação neonatal. *Gerais: Revista Interinstitucional de Psicologia, 4*(2), 228-241.
- Feliciano, D. S., & Souza, A. S. L. (2011). Para além do seio: uma proposta de intervenção psicanalítica pais-bebê a partir de dificuldades na amamentação. *Jornal de Psicanálise, 44*(81), 145-161.
- Fleck, A., & Piccinini, C. A. (2013). O bebê imaginário e o bebê real no contexto da prematuridade: do nascimento ao 3º mês após a alta. *Aletheia, 40*, 14-30.
- Gillespie, A. H., & Acterberg, C. L. (1989). Comparison of family interaction patterns related to food and nutrition. *Journal of the American Dietetic Association, 89*, 509-12.
- Gonçalves, M. J., & Rodrigues, E. (1998). As perturbações alimentares precoces e a sua avaliação. *Análise Psicológica, 16*(1), 127-138.
- Hewetson, R., & Singh, S. (2009). The lived experience of mothers of children with chronic feeding and/or swallowing difficulties. *Dysphagia, 24*, 322-332.
- Junqueira, P. (2017a). *Por Que meu filho não quer comer? Uma visão além da boca e do estômago*. Bauru, SP: Idea.

- Junqueira, P. (2017b). *Relações cognitivas com o alimento na infância*. São Paulo, SP: ILSI Brasil - International Life Sciences Institute do Brasil.
- Kerzner, B., Milano, K., Maclean Jr., W. C., Berall, G., Stuart, S., & Chatoor, I. (2015). A practical approach to classifying and managing feeding difficulties. *Pediatrics*, *135*(2), 344-53.
- Klein, M. (1996). Uma contribuição para a psicogênese dos estados maníaco-depressivos. In M. Klein. *Amor, culpa e reparação e outros trabalhos (1921-1945)* (p. 301-329). Rio de Janeiro, RJ: Imago.
- Lebovici, S. (1987). *O bebê, a mãe e o psicanalista*. Porto Alegre, RS: Artes Médicas.
- Lefton-Greif, M. A., & Arvedson, J. C. (2007). Pediatric feeding and swallowing disorders: state of health, population trends, and application of the international classification of functioning, disability, and health. *Seminars in Speech and Language*, *28*(3), 161-165.
- Melo, D. S., & Frizzo, G. B. (2017). Depressão, ansiedade e suporte familiar para mães na primeira hospitalização dos filhos. *Psicologia, Saúde e Doenças*, *18*(3), 814-827.
- Morris, S., & Klein, M. D. (2000). *Pre-feeding skills: a comprehensive resource for mealtime development* (2nd ed.). Tucson, AZ: Vital & Marts.
- Müller, P. W., Marin, A. H., & Donelli, T. M. S. (2015). Olha o aviãozinho! A relação mãe e bebê com dificuldades alimentares. *Aletheia*, *46*, 187-201.
- Ramos, M., & Stein, L. M. (2000). Desenvolvimento do comportamento alimentar infantil. *Jornal de Pediatria*, *76*(supl 3), S229-S237.
- Rapoport, A., & Piccinini, C. A. (2011). Maternidade e situações estressantes no primeiro ano de vida do bebê. *Psico-USF*, *16* (2), 215-225.
- Silveira, R. S. D., Lunardi, V. L., Lunardi-Filho, W. D., & Oliveira, A. M. N. D. (2005). Uma tentativa de humanizar a relação da equipe de enfermagem com a família de pacientes internados na UTI. *Contexto de Enfermagem*, *14*, 125-30.
- Soulé, M. (1987). O filho da cabeça, o filho imaginário. In T. B. Brazelton, B. Cramer, L. Kreisler, R. Schappi & M. Soulé (Orgs.), *A dinâmica do bebê* (p.132-169). Porto Alegre, RS Artes Médicas.
- Stern, D. N. (1995). *The motherhood constellation: a unified view of parent-infant Psychotherapy*. New York, NY: Basic Books.
- Toomey, K. A., & Ross, E. S. (2011). SOS approach to feeding. *Perspectives on Swallowing and Swallowing Disorders (Dysphagia)*, *20*(3): 58-93.
- Williams, S., Witherspoon, K., Kavsak, P., Patterson, C., & Mcblain, J. (2006). Pediatric feeding and swallowing problems: An interdisciplinary team approach. *Journal of Dietetic Practice and Research*, *67*(4), 185-190.

Winnicott, D. W. (2002). *Os bebês e suas mães*. São Paulo, SP: Martins Fontes.

Received: Nov. 06, 2018

Approved: Feb. 25, 2019

Vanessa Souza Gigoski de Miranda: is a Speech therapist. She has taken Specialization in Intensive Care at Universidade Federal de Ciências da Saúde de Porto Alegre/RS - UFCSPA and Master's degree in Pneumology at Universidade Federal do Rio Grande do Sul - UFRGS, and she is working towards her PhD in Pediatrics at UFCSPA.

Katherine Flach: is Psychologist. She is an Intensive Care Specialist by UFCSPA as well as Individual, couple and family therapy Specialist by Instituto da Família de Porto Alegre/RS - INFAPA, she has taken Master's degree in Clinical Psychology at Pontifícia Universidade Católica do Rio Grande do Sul - PUCRS, and currently she is a PhD student in Health Sciences at UFCSPA.