"The child does not eat"

Infants' feeding disorders and their therapy[1]

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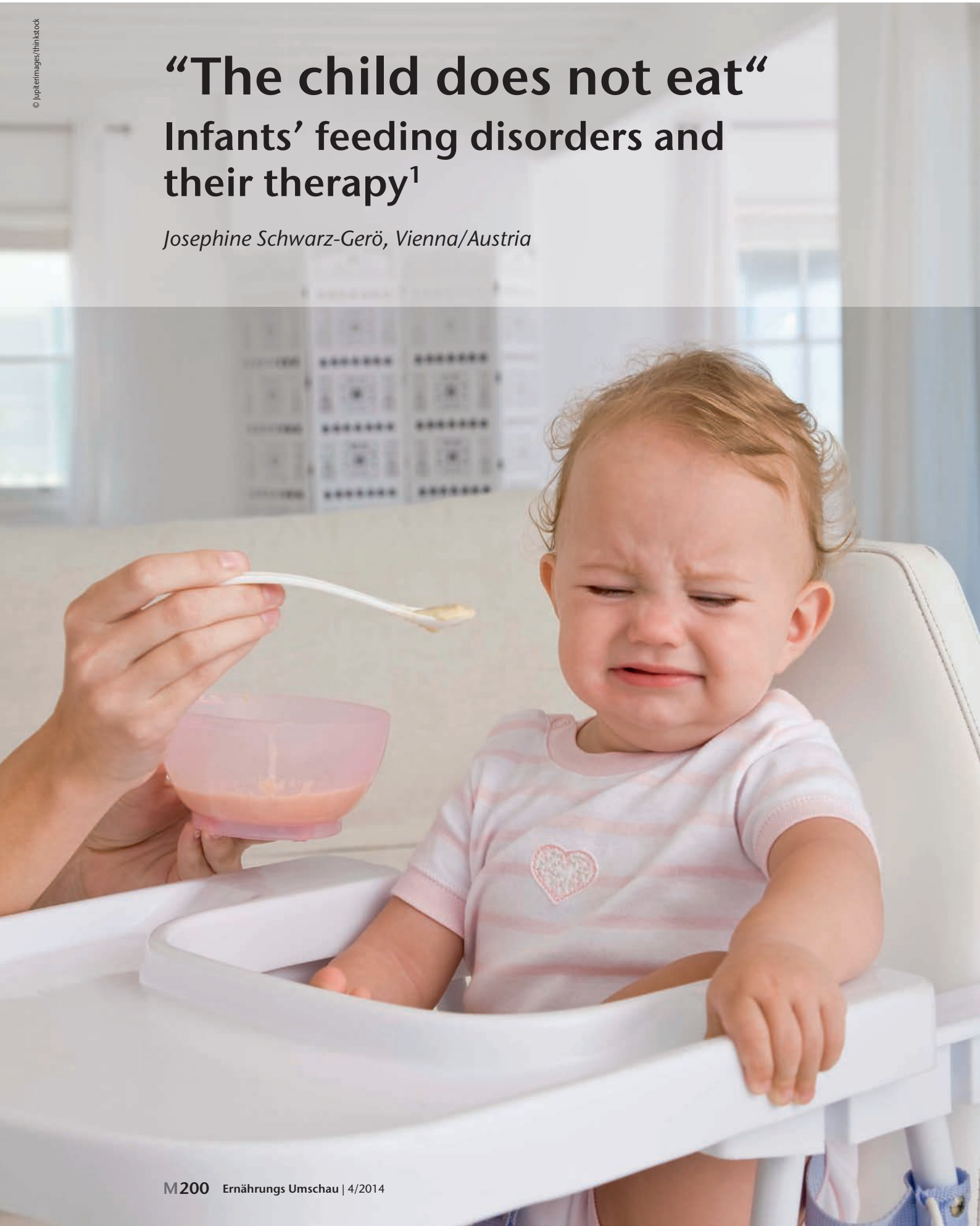

Eating and feeding disorders[2] in early childhood are a common problem, which puts paediatricians, child therapists and other professional groups under as much strain as the parents and children concerned. Families with infant feeding disorders are regularly treated at the infant psychosomatics department in the Wilhelminenspital in Vienna; the causes of these disorders and the treatment thereof are presented in this article.

25–40 % of all infants and young children are affected by eating and feeding problems, at least periodically. For children with underlying complaints and those born prematurely this figure is around 80 %. 5–10 % of all children suffer from feeding problems which are so pronounced that they are referred to as manifest feeding disorders. For 3–4 % there are clear physical consequences in the sense of a failure to thrive [1, 2]. The reasons for feeding disorders are diverse and can be understood as "presenting symptoms" for underlying conflicts.

Characteristics of eating problems in early childhood

A psychodynamic comparison of eating problems in early childhood with those in adulthood undoubtedly shows similarities, but also, clear differences. These differences lie primarily in the nature of early childhood development with its rapid succession of childhood development phases and the resultant rapidly-varying, differing needs. As the linguistic approaches to solving problems in early childhood are limited, behavioural observation – of the child and the parents –, body language and mimicry and overall interaction are paramount in the diagnosis and therapy.

„Parental stress factors are particularly important in all types of feeding disorders"

Early childhood eating problems are directly linked to social dynamics and relationship. For infants and young children, mealtimes are interactional encounters that take place several times a day, during which the child experiences how it is understood and evaluated by its parents – and re-orients itself to this reflection.

Interaction is defined as the totality of verbal and non-verbal signals from one person to another and the ensuing reciprocity. It is the observable expression of internal attitude and relationship and corresponds to a dynamic system. When the child's signals are repeatedly and over a long period not perceived or are misinterpreted and there is either no response at all or the response is inadequate or delayed, this is referred to as parent-child interactional disturbances [3]. These interactional disturbances can lead to typical symptoms such as e.g. excessive crying behaviour, eating disorders, sleeping disorders and other developmental peculiarities. In the field of infant psychosomatics, these symptoms in the child are primarily understood as presenting symptoms of the child's underlying conflicts. This is also the case for feeding disorders.

Aside from misguided ideas on how to bring up the child and encumbered relationship experiences with their own family, the parents' earlier or manifest eating disorders should also be noted. Risk factors include traumatic experiences during the pregnancy, birth or neonatal period. Anxieties experienced by parents during these phases of life can already be reactivated by a simple temporary loss of appetite in the child. Yet parents must not only be regarded as the cause of these conflicts. Particularly in the case of post-traumatic, genetic and physical stress, when the child's signals are contradictory and hard to understand, parents can assist their child therapeutically as part of specific therapies and help to solve these conflicts.

Development of feeding problems and disorders

In the development of feeding problems and disorders, we can distinguish between load and risk factors (e.g. in-vitro fertilisation, premature birth, trauma in the neonatal period, parental anxieties and biographical stress factors), triggering causes (infections, hospital stays, birth of

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[1] This article is a revised and expanded version of the article: "Das Kind isst nicht." In: Arzt und Kind, Issue 5/2013.

[2] The term "Fütterstörungen" is commonly used in Germany; the terms "Fütterungsstörungen" and "Fütterungsprobleme" are more common in Austria.

a brother or sister, parental conflicts, postpartum depression) and the self-reinforcing tendencies inherent in all interactional problems. As these interactional self-reinforcing tendencies can also occur when the child's eating problems are purely physical, a strict division between physical and non-physical feeding disorders should no longer be maintained – and is also in practice not very helpful [4]. For a feeding disorder and/or failure to thrive to be clarified, both a physical medical diagnosis and an interactional diagnosis are required, as well as professional observation of the feeding situation.

Etiological reasons for feeding disorders

Feeding problems and disorders are undoubtedly a heterogeneous and poly-etiological phenomenon; but to parents it always seems same: "The child does not eat". The phenomenon begins in special development stages by virtue of a changing dynamic or there finds a new form. If it lasts for a long time, the diverging causes almost inevitably overlap, resulting finally in extremely complex interrelations and effects on the child itself and the whole family structure [4].

To understand this dynamic it is helpful to visualise the individual etiological paths towards the feeding disorder phenomenon (inspired by the classification according to I. Chatoor [2, 5]), individually and in isolation, as below.

1. Feeding disorders of state regulation

Feeding disorders of state regulation are defined as problems that children and infants have adequately regulating their own emotions and behaviour [1]. These disorders mostly begin post-partum. Some of these children have difficulties in state regulation, are highly irritable and rarely attain a state of calm, alert attentiveness. They show rapid shifts in mood and are barely able to calm themselves. Their sleeping and eating patterns are irregular. In general, they are difficult to understand. They are often referred to as a "fuzzy baby" or a "difficult baby" [6]. Many of them are also "screaming babies".

Typical representatives of this group are children who have been through a premature birth or a deficiency birth. A complicated pregnancy or birth, prenatal stress or drug and alcohol exposure during pregnancy can also lead to disorders of state regulation. On the whole, the cause can be a purely genetic predisposition and epigenetic influence, but can also be a purely secondary occurrence due to e.g. an overregulated interactional style by the parents. In the case of the latter, a superfluity of parental signals and actions leads to a sensory overload for the child – usually also with too few rest periods.

Therapy: The therapy focuses on calm, structure and security. As is often the case with interactional problems, this applies to both the child and the parents, who often appear similarly "difficult" and overwhelmed. In contrast to some modern recommendations to concentrate exclusively on the child, these children often need externally-determined regular feeding and sleeping times as well as deliberately-fixed pauses to process experiences. Regular and more frequent provision of food – yet without the pressure to eat or specified quantities – can be useful and can help the mother and child to relax. When they have strong feelings of hunger, children with state regulation problems can overexert and thereby (paradoxically) impede the act of ingestion. The child can be too irritated to coordinate the act of sucking and swallowing. It is therefore important to calm the child itself before feeding. A stable and secure position for the child is important – possibly even away from the parent's body: not lying in the arms, but e.g. on the nappy-changing table or the bed

Terminological differentiation: Feeding problems, feeding disorders and failure to thrive

By definition we refer to feeding problems, when parents subjectively perceive one. This problem becomes a feeding disorder, if:

- this condition lasts for longer than a month,
- feeding (beyond the 3rd month of life) lasts longer than 45 minutes,
- intervals between meals are less than 2 hours, and
- parents have already actively sought help [1].

Feeding disorders do not necessarily combine with a failure to thrive; both can also exist completely independently of each other. A lack of failure to thrive therefore does not exclude a serious feeding disorder.

Failure to thrive per se is anthropometrically defined by a drop below the 3rd percentile and/or a change of more than 2 weight percentile curves through weight loss or weight standstill over a period of at least 2 months (or three months after the 6th month of life) [1].

Etiological reasons for feeding disorders

1. feeding disorder of state regulation
2. feeding disorder of attachment
3. feeding disorder of separation
4. sensory food aversion
5. post-traumatic feeding disorder
6. feeding disorder associated with concurrent medical condition
7. complex feeding disorders

– along with gripping opportunities for the hands to calm the child. Melodious and calming speech by the parents can also be helpful [4].

2. Feeding disorder of attachment

Feeding disorders of attachment mean the child is not sufficiently thriving and is unwilling to drink, due to a lack of care, emotional deprivation and insufficient stimulation. The child ostensibly appears low-maintenance, un-needy and superficially content. As a result, parents often do not discern a feeding and thriving problem. It is often the paediatrician, who first raises the alarm. These children may attract attention not only as a result of insufficient weight gain, but also as a result of delayed motor development. In pronounced cases, it may also be a matter of early childhood depression. Causes are often to be found in the mother's postpartum depression, conflict between spouses, family crises or transgenerational transmission of negligent relational patterns. Exhaustive depression may also be a cause, as it can appear after a period of caring for a "difficult" baby [7].

Therapy: The therapy for feeding disorders of attachment focuses on the psychiatric and psychotherapeutic treatment of the parents. Although, in this case, the limitations of early intervention therapy are apparent. If alternative, loving and responsive – i.e. encouraging the child's own initiative by means of prompt reaction to children's signals, actions or opinion manifestations – attachment figures are not involved, the child, with its development needs, often cannot wait for lengthy parental therapy, without suffering harm [7].

3. Feeding disorders of separation

Feeding disorders of separation include eating problems, which suddenly arise between the age of 7 months and 3 years or those which clearly worsen during this period. The spoon-feeding phase and the transition phase from the spoon to solid food are technical in terms of eating. In terms of development psychology, this period corresponds to the development of autonomy. In the German language this is also known as "Trotzalter" – the contrary age. This is marked by power struggles and conflicts within the mother-child relationship. E.g. the child refuses food offered, yells or throws crockery. It is claiming its first rights to self-determination in personal matters. It no longer wants to be "infantilised", in the truest sense of the word.

Traditional attempts by parents to solve these issues during this period involve distraction manoeuvres with toys (whilst continually increasing the dose). Forcible attempts at a solution also occur through force-feeding [4].

Therapy: The therapy focuses on the involvement of the "third party", usually the father, and/or his/her increased presence in the family dynamic. In general, new playing rules are established in the family, according to which everyone, and even the child, retains their right to physical self-determination. Therapeutically, the first step is to shape meals according to the abilities of the child. In the first instance, that includes equal participation at the family table. Any conflicts and questions relating to help the child are first and foremost taken care of linguistically (e.g. "shall I help you?", "shall I cut that?") [4].

In general, the age-appropriate modification of speech at the start of the separation phase is an important signal to the child of its orientation and is consistent with its internal changes. By means of mirroring speech that captures the child's frame of mind in words, the child receives feedback, feels understood and learns to understand itself (e.g. "now you are angry", "now you are frightened", "you don't like that"). By means of speech accompanied by actions, it pays attention to its actions and has space for its own plans of action (e.g. "Are you looking for the ball?" "Are you trying to open the bottle?"). The questioning of the child about its personal interests and the expectation of answers or decisions signalises to the child the limits and scope of its new, but age-appropriate, autonomous rights (e.g. "can I wipe that away for you?"). At this age children develop the right to the respect of their physical limits – quite similar to the rules between adults [4]. Crossing the limits triggers anger. Uninvited touching, wordless moving of a chair, encroaching use of the others' plate, etc. are (also) seen as impolite among adults.

In the context of the therapy, the simmering parent-child conflicts of this development phase can be reflected in similar conflicts (namely regarding autonomy) between parents and the support system. For example, advice is requested, yet at the same time rejected or its implementation is scuppered. We also often find familiarly or culturally-conditioned insufficiencies, usually transferred generationally, with regard to appropriate conflict solution strategies. For anyone who only knows the system of winning or losing, power or submission, the strategies of negotiation, association, empathetic change in position or compromise are not available. Another opinion is then perceived as a threat or potential danger.

4. Sensory food aversion

In sensory food aversions, children show a selective eating behaviour. They react with clear signs of revulsion to certain food or foods with a certain consistency, colour, taste, smell or temperature. They move

their face away disgustedly, refuse, retch or spit the food that has successfully been put in the mouth back out again immediately. In the event of new and unknown foods, a kind of "food neophobia" can also arise with signs of anxiety. Children with such eating behaviour are also known as "picky eaters". As parents of these children often report something similar about themselves or from their own childhood, a genetic connection has been debated [5].
Oral hypersensitivity is the accepted explanatory model. This often appears in combination with other sensory abnormalities, such as contact sensitivity or oversensitivity to certain smells and noises. In general, sensory processing particularities and disorders might exist.

Therapy: Therapy is usually lengthy, and the most important thing is to take these particularities seriously and to observe and permit attempts at solutions originating from the child. I.e. in the first instance, in the event of this kind of hypersensitivity, meals should be offered which the child can accept. It should get sufficient opportunity to connect eating in general with well-being and feelings of pleasure and not to associate it increasingly with aversion and disgust. To come out of the spiral of conflict and to counteract malnutrition, it may be sensible, e.g., for a child who does not like meat, to prepare it as a sweet mush. Dry fruit and homemade plates of wholegrain and nuts can be offered to a child who shows disgust for "wet food". Neither parent nor child should be put under pressure. It is important that parents do not obviously limit their own meal at the same mealtimes. They thereby allow the child – enticed by curiosity and the imitative instinct – to taste the food itself at a certain point and thus gradually to "de-sensitise" itself.
The often excessive need of babies and small children to tactilely investigate food at the beginning can also lead to conflicts. This often collides with the parents' ideas of how to bring up a child, in which food is not touched or played with. In this case, parents should curb their ideas and allow their children room for the tactile investigation of food – important for development – , which sometimes helps to override a refusal. The baby may "feel" its food, e.g. with its hands in the mush or grip it on the plate and lick its fingers (cleaning can be done after eating). This topic also plays an important role in therapy for the following eating disorder.

5.Post-traumatic feeding disorder

Post-traumatic feeding disorders can occur as a result of traumatic experiences to the mouth, throat, stomach and intestinal tract occurring at any age. Causes can be both the consequences of medical procedures such as operations, repeated intubation and drip feeding as well as general and intra-familial traumatic experiences to the mouth. That includes the feeling of suffocation when swallowing or pain in connection with food, such as e.g. are presumed in gastro-oesophageale-reflux. Particular importance is given to the child's experience of violence, as it may sometimes experience with forced teeth cleaning and force-feeding.

In eating situations such children show all the signs of fear, panic and the need to escape. They begin to scream when they see food, try to twist free or to hide. After repeated force-feeding they may also, as is the case after chronic child abuse, passively take in food with a pale, numb face and then regurgate afterwards.

Therapy: Similar to sensory food aversion therapy, the therapy for these children can require a lot of time. Aside from the immediate halt of violent treatment (and parental therapy), it is important to create new possibilities for eating, unburdened by earlier negative associations, e.g. meals on the floor as a picnic or creative experiments with food. Through age-appropriate and playful opportunities (see above), which the child itself can control and actively shape, it can be encouraged to regain confidence in eating situations and in its attachment figures [4].

6. Feeding disorder associated with concurrent medical condition

Doctors are essentially aware of a whole range of diseases associated with nutritional and feeding problems. These encompass almost all organ systems, such as e.g. neurological, chromosomal and metabolic diseases, those of the stomach, intestinal tract, kidneys, mouth and jaw area, heart and lung diseases and immunological disorders. Nevertheless, a physical diagnosis does not exclude an additional feeding disorder as described above. In contrast: Due to the high number of stress factors, which physically ill children and their parents encounter (e.g. repeated hospital stays, the parents' justified existential fears and typical interactional self-reinforcing tendencies), it is actually very probable. Sometimes the differentiation is firstly delivered "ex juvantibus", i.e. after the execution of parent-child interactional therapy. It is therefore advisable to combine clinical physical investigation and therapy with video-supported interactional diagnosis and therapy.

7. Complex feeding disorders

In practice, the above-mentioned feeding disorders rarely appear in their pure form. Due to the child's rapidly-progressing development and the self-reinforcing tendencies of the disorder, several of the forms described above often occur in com-

bination and overlap in layers at the same time. There are undoubtedly children who exhibit all the above-mentioned disorders at the same time. These complex feeding disorders, often in combination with tube feeding, require hospitalisation and therapy in a specialist centre.

Therapeutic approaches for feeding disorders

The therapy concept for feeding disorders in infant psychosomatics corresponds in practice to the general therapy concept for parent-child interactional disorders. In keeping with the multi-factorial aetiology, the therapy concept also applies at the same time to the parents, the child and the interactional dynamic between both.

The key therapy modules are:

- psychoanalytical psychotherapy for at least one parent,
- behavioural therapy measures towards the child, and
- video-supported interactional diagnosis and therapy.

The key medium for infant psychosomatics at the Wilhelminenspital in Vienna is video technology [8].

In the video-supported interactional diagnosis and therapy, targeted video recordings are made of everyday interactional sequences between the mother (father) and child, such as e.g. feeding scenes, nappy changing, bathing and playing.

These are analysed and discussed together with the parents. The reproducibility of the medium allows for different consecutive therapeutic focuses: in terms of the child, these are usually its individual character, its temperament, its development phase and the timing and type of signals. In terms of the parents, it is their responsiveness and actions, their verbal expressions, their mood, their feelings and associations – particularly in key scenes. Depending on the focus, circumstance and need, these videos can thus be used for advice and tactfulness training, as well as for analytically-oriented psycho-

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As part of the therapy, video recordings of everyday interactional situations between the parents and the child are analysed.

Vienna model of infant psychosomatics

The Vienna model of infant psychosomatics has proved highly successful during its 20-year existence and enjoys an excellent reputation across Austria. Infant psychosomatics has meanwhile become a fixed element in early childhood healthcare in Vienna. It is part of child and youth psychosomatics in connection with a paediatric clinic and is located in a municipally-owned large hospital.

Having expanded over the years, the department currently consists of a full ward, a day clinic and an outpatient area ("crying unit"). Therapy success rates are 96 %. Limiting factors are primarily language barriers and severe psychiatric illnesses in the parents.

In line with the diversity of interactional disorders, referrals come from paediatric clinics and paediatricians, pre-school, mobile midwives, speech therapists, outpatient advice centres, perinatal psychiatry and child welfare offices. Sometimes children are taken on directly from its in-house neonatal intensive care unit. The patient population suffering from feeding disorders, including tube feeding, is currently approx. 40 %. Parents, who are often under high psychological stress, are very open-minded to the therapy. The waiting list is usually around several months. The Vienna Infant Psychosomatics Department has international connections via the German Association for Infant Mental Health (GAIMH) with members in Germany, Switzerland and Austria.

therapeutic intervention. In the latter, the underlying relational level is broached and processed based on the observable interaction. Through this process, parents are made aware of parental projections onto the child and biographical aspects are thus connected.

The therapeutic process is supported by means of gradual changes in interaction planned with the parents and their repeated video documentation with its associated analysis [7]. The therapeutic strategies are based on the dynamic system of mutual influence and reaction. The child is similarly understood as an individual as well as "part of the parents". One of the key strategies of the therapy is to give the child the opportunity to apply its abilities and at the same time to enable the parents to perceive them.

In her book "Baby, warum isst du nicht?" (Baby, why aren't you eating?) Dr Josephine SCHWARZ-GERÖ extensively explains feeding problems and disorders, illustrating them with a variety of case descriptions from her professional experience in infant psychosomatics. The book is aimed at everyone who works in the advice and therapy of young families, as well as affected parents.

We have already presented the book in Ernährungs Umschau 6/2013 on page M364.

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Conflict of Interest
The author declares no conflict of interest according to the guidelines of the International Committee of Medical Journal Editors.

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