From 1957 to 1979 Dr. George Stroh was Psychiatrist-in-Charge of High Wick Hospital, St. Albans, where he and his colleagues worked with severely disturbed children. The hospital was perhaps unique because of the particular attention given to feeding disorders. Unfortunately, Dr. Stroh's untimely death in 1979 meant that he could not present the material he was gathering in a systematic paper of his own. Our purpose is to present some of his results and conclusions, as well as further findings we have made in the intervening years in our practice in London.

Over a period of nine years we explored the use of feeding as a therapeutic measure for severely disturbed children at High Wick Hospital. Originally we had intended to make a particular study of psychotic children, but as our work progressed we realized that the ideas were relevant to all disturbed children, and that the basic principles could be generalized and were beneficial when feeding normal infants.

Our main purpose is to describe a technique which may help a wide range of children, so we will not discuss terms such as autism or psychosis. We choose to use the broad term 'severely disturbed children', and a few of the children involved in the feeding programme are described.

Theoretical perspectives

The importance of treating feeding difficulties was emphasized by Clancy and her colleagues in Australia (Clancy and McBride 1969, Clancy et al. 1969). They described a feeding programme for autistic children and noted that, with improvement in eating, 'significant changes also occur in other facets of behaviour'. Our feeding programme was based on Clancy's work, and was first used at High Wick in a pilot study with one child (Stroh 1974).

There have been programmes for helping physically handicapped children to feed, for example those of Harkness and Sandys (1970), Morris (1977) and Warner (1981), but for the most part they deal with the 'mechanics' of eating, very little consideration being given to the emotional aspects or the relationship between child and feeder. Peculiar eating habits are referred to in the literature. Tustin (1983) found '... early difficulties in sucking to be characteristic of all the autistic children I have seen ... weaning difficulties [are] also characteristic ... time and again the parents of an autistic child have told me such things as “he will only eat soft food and rejects hard lumps” or that “he will only eat semi-liquid food”'. Rimland (1962) mentioned feeding problems in his description of specific problems and
behaviours of autistic children: 'Feeding problems are almost the rule. Some children have ravenous appetites; others eat very little. Almost all have odd eating habits and preferences, however'. Wing and Wing (1971) talked of the multiple impairments in childhood autism but made no specific mention of eating disturbance. Presumably they, with many others, regarded feeding problems as secondary manifestations which were non-specific and not significant (indeed, a computer search of the literature seems to confirm this).

Two accounts of 'normal' feeding are worth mentioning. R. Thomas writes: 'Of all the strange things a child will do, the strangest and incidentally the commonest must surely be this refusal to eat some things, more rarely a pretty general refusal to do more than pick at food'. Ainsworth and Bell (1969) looked very closely at the feeding patterns of 26 normal babies: their table of patterns of mother-infant interaction during feeding showed that there were problems with almost all of the infants, e.g. colic, spitting up, gastric distress, unhappy feedings.

It is our impression that most severely disturbed children show significant eating abnormalities, though some may be disguised or not be regarded as significant. Among the most common types we have noted are: (1) automatic, mechanical eating; (2) shovelling food, gulping, stuffing; (3) not chewing; (4) avoiding touching food with the lips, not looking at food; (5) spitting or regurgitating; (6) throwing food; (7) scavenging, grabbing food from other people's plates; (8) excessive fads or refusals; (9) patterning of food; and (10) holding food in the mouth for long periods.

With regard to the importance of early feeding experience in general, Kanner (1973) has stated that 'Food is the earliest intrusion that is brought to the child from the environment. It is the basis of judgement, of deciding: is this good or bad? The judgement is 'I should like to eat this' or 'I should like to spit this out' (Freud 1925). Furthermore, the early feeding experience, that is the giving and taking of food, is probably the most important aspect of that intimate interaction between mother and baby we call mothering.

We think that early feeding difficulties give rise to the faulty development of the disturbed child. If in infancy eating is unpleasurable, it does not change discomfort into comfort, but tends to increase discomfort. Eating then becomes a threatening experience, and a vicious circle is set up so that fundamental conflict exists between the basic need to eat and the intense fear of doing so. The conflict is resolved by the process of 'non-eating eating' (Stroh 1977), which allows food to be taken in in an affectless way, in a state of relative unawareness.

The feeding programme
Our feeding programme provides a situation in which a child, on his own initiative, breaks through his basic feelings of mistrust. By subsequent pleasurable feeding interaction with a 'feeder', he is then able to make a more normal adjustment to his environment.

High Wick Hospital is a small residential psychiatric unit for up to 18 children ranging in age from three to 13 years. Their length of stay was from one to several years, depending on the severity of the disturbance. The day-to-day care of the children was undertaken by 10 child-care workers. The children were divided into groups of between three and five, each group being under the care of two child-care workers. Within each group, one child-care worker was responsible for between one and three children. In this way a high degree of consistency and continuity of care was achieved.

The buildings in which the children lived and engaged in school and other activities were part of a large Victorian country house in four acres of ground. The accommodation for the child-care workers was a similar house across the road, which also contained an attic flat used for the individual feeding sessions. The Flat contained a kitchen, bedroom, playroom, bathroom and dining room with video equipment and a one-way screen.

The school was an integral part of the unit, and there was a daily programme of structured activity for which the children were divided into school, nursery or pre-nursery groups, each run by a teacher
assisted by child-care workers. The teaching programme provided for the individual needs of each child and was based on what we came to call the 'functional learning' technique*. Some children had individual psychotherapy and speech therapy. The Psychiatrist-in-Charge (G.S.) was responsible for the administration of the unit and for its planning, after discussion with all the staff. A social worker did the major part of the counselling, support and treatment of parents.

A feature of the unit was the attempt to integrate social, therapeutic and educational aspects of care with the day-to-day care of the child. Factors which helped were the participation of child-care workers in the teaching and activity groups, regular meetings to discuss the children involving all members of staff, and an in-service training programme for child-care staff.

During the first phase of the feeding programme the child lived in the attic flat, and treatment began after the child had settled into the new environment. All meals were taken in the dining room there, which contained a small table and two chairs. The walls were covered with acoustic tiles to reduce noise. At the three usual meal-times each day the child came into the dining room and sat at the table near the feeder (K.S.), who was known to the child. At this stage only a plate of food, a spoon and occasionally a glass of juice or water were on the table. The food, which was kept to a single course, was always bland and easily digestible, e.g. mashed potatoes or minced meat, and only small amounts were presented at each meal. The food was offered on the spoon, with the feeder watching for any cues the child might give, however minimal. There was no persuasion or cajoling at any stage, since the initial aim was for the child to accept food from the feeder. The feeder always remained relaxed and friendly, while making minimal verbal contact with the child. If the child continued to refuse the food after 10 to 15 minutes the plate was taken out of the room without comment. This procedure was repeated at each meal-time. Only water or juice were allowed between meals, when the child had the use of the flat and was looked after by a parent or child-care worker. Sometimes there were walks; at other times the child remained in the playroom. No child ever looked for or asked for food between meals.

The child might refuse food for some days, and the conflict between accepting or rejecting it became intense. Two of the three children discussed later lost weight slightly but the third did not. Eventually each child did accept food, and with this came a closer relationship with the feeder and increased awareness of the surroundings. The child gradually came to feeding himself and the bland food was replaced by a more varied diet. After two to four weeks the child returned to the main building, where the prolonged second phase of treatment began (this is discussed in Part II of this study).

In all cases the feeding programme began only after full discussion with the parents, who were made aware of the stresses and tensions that could arise during the non-eating period. Whenever possible both parents were encouraged to become fully involved, preferably living in the flat over this period. If this was not possible the 'mothering' role was taken by a child-care worker.

The one-way screen in the dining room was used for observation and video-recording, so films of each meal were available for the feeder, parents and child-care staff to discuss. Throughout the treatment the children were monitored by a paediatrician and electrolyte balance was checked daily.

Case reports

All three children described here were seven years old when they began the feeding programme. Before coming to High Wick they had been seen by many agencies and had been subjected to various methods of treatment. All three children came from families who remained caring, despite years of frustration. However, their behaviour finally made it impossible for them to remain at home. Progress in language and learning were minimal, and
one boy had no language progress at all. They all had feeding problems, which had become gross by the time they were admitted to the unit.

After admission the children settled and made social gains. Treatment included the two essentially different procedures, the brief feeding programme and the slow and painstaking building on the results of that to deal with educational, language and emotional problems (Stroh et al. 1985).

MARK
Early history
Mark had been born at term and delivery was normal. His mother was a medical student from Austria, in her final year. His father, a teacher, was English. He had been breast-fed on demand and supplementary feeding was started at six weeks. Weaning began at 3½ months and was completed at 4½ months, when he suffered the first of two major separations from his mother, who returned to Austria for five months to complete her medical studies. Mark was looked after by foster parents, and he seemed to accept his mother when she returned. During the second separation lasting for two months, at the age of 13 months, Mark was looked after by his paternal grandmother in his own home. When his mother returned he did not recognize her. He regressed, stopped babbling, screamed a lot and became faddy about his food.

After the birth of each of his two brothers he suffered the first of two major separations from his mother, who returned to Austria for five months to complete her medical studies. Mark was looked after by foster parents, and he seemed to accept his mother when she returned. During the second separation lasting for two months, at the age of 13 months, Mark was looked after by his paternal grandmother in his own home. When his mother returned he did not recognize her. He regressed, stopped babbling, screamed a lot and became faddy about his food.

During the fifth to seventh days the video-recordings showed his increasingly heart-rending facial anguish and distress. His noisiness decreased and he became hopeless and helpless, but was exquisitely sensitive to the sound of the spoon on the plate. There was now a real pull towards the food as he made prolonged, silent contact with his fingers on the edge of the plate.

Mark chose to eat on the seventh day, taking tiny bites of food and spitting some out. His distress returned, but the meal ended with a warm verbal communication between Mark and the feeder. Acceptance of food did not become established for a few more days, but after this he fed himself, learning to trust, taste and enjoy a wide range of foods, both at High Wick and during weekend visits to his home.

ZEEV
Early history
Zeev was born in South Africa of Israeli parents, who came to England when he was two. He had a younger brother, who was a bright normal boy. Zeev's birth had been normal and he was breast-fed for three months—'a hungry, greedy baby who sucked very hard'. There were no indications of delay in physical development, but he became an irritable, crying baby.

*G.S. on Mark: 'The defensive armour is the essential part of his disturbance which prevents him from adapting and adjusting in anywhere near a normal way. The defensive armour is the autism, it is self-defeating in that it prevents adjustment. In behaviouristic terms it is self-perpetuating, a faulty learned behavioural pattern, in psychoanalytic terms there is no libidinal development, except perhaps primary narcissism. He projects onto the food, or the food becomes, the totality of the hostile world or hostile feelings, against which his autistic defence is directed. It ceases to be a gesture of apparent defiance (which it never quite was); rather, it could be understood as a need to preserve the fantasy, to be in complete control—what he cannot control he excludes, and therefore it does not exist. This is a primitive mechanism used when confronted with situations which are not understood or do not make sense. There can be many reasons why situations are incomprehensible, for example when his omnipotence is challenged, or when he can no longer exclude the experiences that maintain the fantasies. Only by mobilizing some of his libido, moving from primary narcissism onto the food (outside) will he be able to develop object relationships and all that grows from this'.
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unresponsive child who soiled and wet and refused to sit down for meals. His mother followed him around with two bottles of juice, putting the full one into his mouth when he dropped the empty one on the floor. At three years of age he was diagnosed as autistic and at five years he came to High Wick.

Response to inpatient care
Zeevi moved about bent double, almost on all fours, scavenging everything so that his fists were full of dust, dirt and tiny objects which he might cram into his mouth. He was always active, but his activities were limited, non-integrated and self-perpetuating.

Most of his attention was given to objects: he ignored the other children and made only minimal contact with adults. He became toilet-trained and started to use a spoon and to sit at the table, but his food fads continued. He had no speech sounds, but his previous noisy distress sounds were replaced by good-natured laughing and giggling, particularly when he was tickled. However, his behaviour patterns were absolutely rigid and he was unable to tolerate change in them, or indeed any kind of change.

During the early months at High Wick Zeevi's mother visited weekly, but these visits stopped when the family settled in America. The parents did visit once or twice a year, and during one of these visits, when Zeevi was seven, we discussed the feeding programme. They agreed, though obviously the absence abroad meant they were unable to participate. A research worker was assigned to 'special' Zeevi throughout the day, apart from meal­times, when he would be with the feeder. He spent the day in the attic flat, but returned to the main building to his usual bedroom at night.

Feeding
During the first two days Zeevi sat at the table and took minute bits of food after 'modifying' it in various ways. He did not allow the spoon to enter his mouth; instead he used his fingers to take food off the spoon, then smearing, moulding or patterning it on the table or on the sleeve of his sweater. Some burlesque 'defence' and bizarre facial movements accompanied this food 'play', but he became distressed, shut his eyes, buried his head on the table and refused more food.

His refusal lasted for another 12 days, during which he drank water or juice and suffered little weight-loss. There was never any catastrophic distress or loss of control. However, his mood and behaviour changed dramatically from day to day as he varied his defensive manoeuvres, to such an extent that often only in retrospect were we able to make some sense of his confusing signals or cues.

On days three and four Zeevi became increasingly aggressive, attacking the feeder's hand and trying to force-feed her—now the food was more clearly a threat. On other days he wept, grizzled and screamed. On day seven he made his first real speech-sounds when he pushed the plate away with 'go-go-go'. At times there was a growing awareness of the feeder as a person, as he left his chair and sidled up to her, holding his plate. Some of his noises began to sound like a normal baby's distress sounds.

The most difficult behaviour to cope with was his ultimate retreat into a kind of chanted singing, which he could maintain for a whole feeding session. This led us to change our procedure in an attempt to make contact with Zeevi. On day six he was offered food on the feeder's finger to help him overcome his aversion to the spoon. However, this only seemed to increase his confusion and he retreated to earlier defensive behaviour. On day 11 we modified the situation so that Zeevi could take part in preparation of the food: he grabbed, bit and scavenged, and the food seemed to become more rather than less threatening.

We wondered whether this behaviour could be linked to earlier difficulties with weaning and decided to offer him fluid and solids separately. This time the response was dramatic, as he allowed sufficient milk to come in contact with his teeth to blow or spit it out onto the table. The feeder allowed this 'in and out' as an acceptable rhythmic pattern. The session ended with Zeevi picking up the cloth and wiping the table and his mouth with it before handing the cloth to the feeder—an ambivalent response to the food, but a pleasurable interaction. Despite our willingness to join in with the spitting response, we were not aware at the time that in fact this was the breakthrough we had been working towards. Slowly and hesitantly, Zeevi began to eat a variety of food and to take part in the preparation and cooking. Recognizing his real aversion to milk, by using preferred food we slowly weaned him onto it, so that by day 39 he was pouring milk and drinking it from a glass, accompanied by a wordlike sound 'more-milk'. Zeevi's practice and use of language associated with pleasurable food laid the foundation for his emerging language.

STEFANO

Early history
Stefano was born in Italy, the only child of an English mother and an Italian father, both of whom were civil servants. From the beginning there were feeding difficulties: he sucked slowly, ate very little and needed cajoling. Stefano's mother felt inadequate and unsure of her mothering role. She returned to part­time work when he was two months old and he was looked after by an Italian-speak­nanny. There was much mistrust and friction between the two women and eventually his mother took full charge of him again when he was two years old. He had started to walk, but made no effort to explore his surroundings.

He cried a lot, used gestures, and had a variety of confusing speech-like sounds. From the age of three his parents tried to find help in Italy but were unsuccessful. When he was seven his mother brought him to England and he was admitted to High Wick.

Response to inpatient care
Stefano was a well-built, not unattractive boy with a fatuous, empty lop-sided grin. He was clumsy and he toe-walked and flapped his hands. He could do very little for himself in the way of washing and dressing, nor could he open a door. He tended to cling to adults or make no effort to explore his surroundings. He cried a lot, used gestures, and had a variety of confusing speech-like sounds. From the age of three his parents tried to find help in Italy but were unsuccessful. When he was seven his mother brought him to England and he was admitted to High Wick.

Meal-times were very difficult at first, but after about eight months Stefano could be contained in the
Feeding
During the first 16 days Stefano accepted simple food (eggs, toast, potatoes, milk) from the feeder. His initial frozen body-posture alerted us to the possibility that he had been force-fed in his early years, and his mother was able to confirm this. We began to understand the parasitic rather than symbiotic nature of the mother/son relationship: their interactions perpetuated a state of fusion and total dependency, preventing Stefano's growth of initiative or assertion of independence. The feeder learnt not to collude with or reinforce either of his extremes of passivity or destructive, manipulative behaviour. After 16 days Stefano had hesitantly begun to feed himself and was showing more appropriate affect and increased understanding.

On day 17 his mother became the feeder for the first time, although she had been in the room several times before then. Stefano acted as he did to any new experience, accepting the food passively and without pleasure: it became a 'non-eating eating' experience with his mother in control. The mother continued to feed him three times a week for six weeks, then once a week for four months. Time and again Stefano and his mother faced the type of trauma reminiscent of his early years—missed or misunderstood cues, tensions and mood changes, control and confrontation.

One of the critical feeds was when Stefano was given a new food, stewed apple. He did not seem to like it, though he accepted it passively at first. At the next meal he was more resistant and by the third meal he showed definite anxiety, which was reinforced by his mother's obvious anxiety. She would have preferred to avoid this slight displeasure (and other sources of tension) rather than helping him overcome it.

Another feed started with brief spells of eating, then exploded into a battle of attrition as Stefano's flailing arms and relentless screeching reduced his mother to perplexed, angry hopelessness. Her words, aimed at regaining control, only escalated the confusion: 'Go and pick it up... Stefano, sit down and don't move'. During the video replay the mother said 'What's the use of going on, nothing is ever going to change. It's all hopeless, just like the past'.

Stefano's mother did become more conscious of her own moods and attitudes as the feeding sessions progressed. Her confidence increased, her timing became more sensitive to Stefano's cues, and her ability to share rather than take over produced pleasurable interaction. Stefano also initiated a feeding game. It started when he blew through a straw, bubbling the milk he was drinking. After looking a little apprehensively at his mother, he offered her the glass with the sounds 'Ma-ma oo-oo'. She responded playfully and this 'game' was repeated over the last few weeks of the feeding programme. It was the first real sign of intimacy, which lead to 'chatter' of a far different kind than we had heard from Stefano before. He began to tell his mother about daily activities, accompanied by searching visual contact with her.

Associated responses and follow-up
The feeding programme brought about a number of changes common to all three children. They were able to return to their 'family' groups in the main hospital for meal-times without disruption; they began to eat a wide variety of foods; and they enjoyed food. They all showed increased understanding, were able to start learning, and had immediate changes in behaviour. They showed more appropriate affect, more social awareness, and were less overtly aggressive. They responded more appropriately and adequately to simple requests and began to enjoy a variety of activities. Their verbal language increased (in the case of Zeevi, from none to some 300 words in the first three months), and they slept better. They were no longer a problem to handle at High Wick or at home. All the children continued to make slow progress over a follow-up period of eight years.

There was one major difference between the children in their response to the feeding programme. Mark and Zeevi went through a period of not eating*, but Stefano did not refuse food. There seemed to be no obvious

*The anxiety associated with such refusal had been likened to that of the anorexic. However, the anorexic patient chooses not to eat for psychologically different reasons. Crisp (1973) states that the latter disorder 'is primarily one of the psychological meaning of bodyweight with reference to puberty. Some aspects of our feeding treatment and the treatment of anorexia are similar—the early relative isolation, the 'unequivocal' (Kalucy 1973) offering of small amounts of food, and the need to maintain positive transference and therapeutic counselling for the family. Unlike anorexic patients, our children's refusal was short-lived and did not recur.
reason for this difference. Stefano's psychopathology was different from the other two children, his level of understanding was greater, and his early experience made modification more likely. Also his mother was available to take over the feeding, and our focus in this case was to help both mother and child—to concentrate on their interaction in the hope of modifying her handling and control.

Discussion

We learned certain basic things from the feeding programme with these three children, and with others not described here. The feeding technique must be flexible for each child: while there are general guidelines they should be modified when necessary. We found it best to offer small amounts of simple food on a small spoon near the child's mouth—but not too near—so the child had to make only a minimal effort to take the food. If the food was accepted, the spoon was withdrawn smoothly and held on the plate until the child showed readiness for more.

The feeder should watch for minimal approach behaviour from the child before offering food, and should always be wary of the 'gaping hole'—the meaningless wide-open mouth. We learned that this minimal contact is not necessarily associated with eye contact: many other body cues are available. The feeder may use appropriate verbal responses such as the child's name or naming the food, but must always be attentive or cues from the child may be lost. There is no need to cajole, divert or be punitive. The feeder's face should be gentle, not overtly smiling, but relaxed and accepting. Once the child shows interest in touching the spoon there can be sharing rather than handing over, for example the child feeds himself a mouthful and the feeder gives him the next mouthful, then gradually relinquishes the spoon as appropriate for the particular child.

When the child responds with pleasure the feeder can respond in kind, but even then it must be done in a quiet and facilitating way—and always in readiness for further cues. Ending a meal may distress a child, in which case it might help to share scraping the plate and removing it for washing.

We found the video invaluable for both learning and teaching for the feeder, other workers and parents. It allows subtle cues to be identified which are difficult to see during the actual feeding. It also provides the opportunity for free associations and spontaneous recall of earlier events associated with feeding, particularly by the parents. It is also an invaluable preparation for others who are going to take over the feeding.

The initial feedings are done by one feeder, but once feeding is established or refusal is overcome it is possible—indeed desirable—for others to help. Bonds can be transferred from feeder to caretaker. The interplay between feeder and fed is a shared experience requiring intuition, as well as knowledge and skill. Like all skills, it can only be acquired by doing it, just as the emotional part of the experience can only be had by 'feeling' it.

Feeding is a fundamental language known to all: we have all had the experience of being fed and we all have to eat. Once the bond is established, continuity becomes possible because the feeding periods occur three times a day, which greatly enhances the likelihood of consistency of handling and integration of the experience.

*All of the work described remains recorded on video-cassette. It is our experience that watching these tapes arouses deep feelings, often not very comfortable ones. However, these feelings must be confronted, not avoided. Once people have conceptualized the ideas it is possible for them to apply techniques of feeding with a whole range of children.

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Authors' Appointments

Karin Stroh and Thelma Robinson were both involved with the feeding programme as feeder/therapist and psychologist/teacher, respectively, and with the subsequent language and learning work described in Part II of this study. Although no longer at High Wick, they are continuing the work. Reprints and information about video material can be obtained from Mrs. Karin Stroh, 112 Southwood Lane, London N6 5SY.

SUMMARY

Feeding problems are often commented on in the literature, but very little has been reported on the systematic examination of these problems. In the present study feeding disturbances were treated as part of a full diagnostic and treatment programme for disturbed children in a small residential psychiatric unit. The
feeding programme was based on the early work of Clancy and colleagues in Australia, and consisted of offering the child food in a set situation by the same 'feeder'. A one-way screen was used for observation and video-recording. Three children were described in detail, and a striking effect was the immediacy of change in their feeding disturbances. It is stressed that early feeding difficulties of disturbed children can give rise or contribute to ever-widening faulty development.

Résumé
Un programme thérapeutique d'alimentation. I: Théorie et pratique de l'alimentation
Les problèmes d'alimentation sont souvent commentés dans la littérature mais très peu de chose a été publié sur un examen systématique de ces problèmes. Dans cette étude, les perturbations de l'alimentation ont été traitées comme une partie d'un programme complet de diagnostic et traitement pour des enfants perturbés, dans une petite unité de placement psychiatrique. Le programme d'alimentation a été basé sur les travaux antérieurs de Clancy et collaborateurs, en Australie, et a consisté à offrir une nourriture à l'enfant dans un ensemble de situations distincts mais par le même 'nourricier'. Un miroir semi-transparent a été utilisé pour l'observation et l'enregistrement vidéo. Trois enfants sont étudiés en détail, et le changement immédiat de leurs perturbations d'alimentation a été très frappant. Les auteurs insistent sur le fait que des difficultés précoces d'alimentation chez des enfants perturbés peut donner lieu ou contribuer à accentuer des défauts de développement.

Zusammenfassung
Ein therapeutisches Fütterungsprogramm. I: Theorie und Praxis des Fütterns

Resumen
Un programa de terapéutica alimentaria. I. Teoría y práctica de la alimentación
Los problemas de la alimentación son comentados a menudo en la literatura, pero se ha aportado muy poco sobre el examen sistemático del problema. En el presente estudio, las alteraciones de la alimentación fueron tratados como una parte de un diagnóstico completo y de un programa de tratamiento para niños con alteraciones mentales en una pequeña residencia psiquiátrica. El programa de alimentación se basó en un primer trabajo de Clancy y colaboradores en Australia y consistía en ofrecer el alimento infantil en una situación determinada por el mismo 'donador del alimento'. Se usó un espejo unidireccionable para la observación, así como una grabación en video. Tres niños son descritos en detalle, y un efecto sorprendente fue un cambio inmediato en sus problemas alimentarios. Se pone de relieve que las dificultades precoces en la alimentación de niños con alteraciones mentales pueden ocasionar o contribuir a un fallo en el desarrollo cada vez mayor.

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