

Hungry for Love: The Feeding Relationship in the Psychological Development of Young Children

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Abstract

At a time of increasing concern about childhood obesity, health care practitioners can exert pressure on parents and other caregivers to view meals and snacks primarily as opportunities to control children's caloric intake and thus prevent or control childhood obesity. Yet feeding is about much more than the amount and kinds of food offered: Feeding can have a powerful influence not only on the physical health of children but also on their social and emotional health. The feeding interactions used by parents can support or hinder their children's healthy development and can affect parental satisfaction with parenting. By incorporating basic knowledge of child development into the feeding interactions used by parents, health care practitioners can have an even greater impact on the health of children and parents.

What happens during the first months and years of life matters a lot, not because this period of development provides an indelible blueprint for adult well-being, but because it sets either a sturdy or fragile stage for what follows.

—Shonkoff and Phillips^{1-p5}

Introduction

Our knowledge of children's needs has grown tremendously in recent years. One has only to read the 2000 National Academy of Science report, *From Neurons to Neighborhoods*, to understand the importance of early childhood development, including early brain development.¹ The past decade has seen a large increase in research and communication about brain development, particularly in early childhood.^{2,3} This research tells us that the interactions between parents and their infants or children are very important for human development. The parent-child relationship can provide lifelong gifts, such as healthy brain develop-

ment; a sense of resilience; a sense of being loved and cared for; empathy for others; a desire for and joy about exploring, reading, and other learning; and a sense of being important to others.¹

Equally true is the assertion that a poor parent-child relationship can represent lost opportunity to build genuine love and as such can be destructive through no fault of the infant or child. Neglectful or harmful parenting can wound or damage a child; limit brain development; create unhealthy beliefs about what love is; create a sense of worthlessness; and decrease exploring, reading, and other learning.¹

Attachment research has contributed greatly to our knowledge and understanding of the importance and impact of early parenting. Mary Ainsworth's attachment research in 12-month-old infants opened the door to assessing how mothers relate and respond to their young children and how the resulting mother-child relationship can be characterized as being securely attached, avoidantly attached, or ambivalently attached.⁴ Further research in the field of attachment has shown that children with a secure attachment explore more, are easier to manage, are more resilient, have better social skills, have better relationships with peers, and have more empathy than do children in the other two groups. In other words, the quality of relationships a child has later in life reflect the warmth, responsiveness, and consistency of care experienced by the child in his or her early relationships.

Each interaction between a physician, nurse practitioner, nurse, dietitian, or other health care practitioner and a parent is an opportunity to learn about the parent's relationship with his or her child—and is also an opportunity to build a relationship with the parent. This relationship gives parents the comfort of knowing that another adult is on their side helping them to improve their parenting knowledge, skills, and behavior while they experience and explore the

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challenges, frustrations, and triumphs of parenting.

Often, a most powerful interaction occurs when the parent is influenced by the health care practitioner to better understand, accept, and provide developmentally appropriate care to the child and thus positively affect the child's development, health, and life. An excellent pathway in which to observe and influence this process is seen in the parent-child feeding relationship, a universally important early relationship. Feeding is a major area where parents and their young children have frequent daily interactions that either support or hinder the child's healthy development. These interactions can affect parents' perceptions of their competence at parenting as well as their feelings of closeness to their children and sense of acting in their best interests. Thus, the feeding relationship reflects the parent-child relationship—and feeding struggles often indicate struggle in that relationship.⁵

At a time when childhood obesity is attracting legitimate nationwide concern, anyone can easily miss the greater point and focus on feeding strictly as a way to prevent or control obesity. A parent can thus believe that preventing or reversing the child's obesity is more important than the child. The parent might then feel justified in preventing or controlling the obesity through actions that may be counterproductive and damaging to the child's social, emotional, and physical health while failing to develop the emotional basis for healthy eating habits (eg, stopping when satiety is reached). However, taking no action might be equally damaging. A more helpful approach to the problem of childhood obesity is to address the feeding *relationship*.

Developmental Aspects of Feeding

Feeding is an interactive process that depends on the abilities and characteristics of both parent and child.⁶ A positive feeding relationship is essential for a child's proper nutrition and growth.⁷ In addition, interactions related to feeding have a powerful impact on how children feel about themselves and the world.⁷

The following example speaks to the emotional well-being of both the child and the parents; these can be addressed by focusing on the parent-child feeding relationship.

Mavis Bomengen, RN, a public health nurse in Lakeview, Oregon, was working with a mother to help her two-year-old son, who was enrolled in the nationwide Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). As part of the WIC visit, Mavis explored the child's mealtime environment and learned that the mother was forc-

ing her child to "clean his plate" at each meal.

The tension and battles that resulted made mealtimes unpleasant for both the child and his mother. Mavis described for the mother the primary feeding relationship concept: division of responsibility. The mother was willing to try to incorporate this concept by letting the child—and not either parent—assume responsibility for how much he ate. However, the mother warned that the response of the child's father would probably be a different story. After three calls to the father, he agreed to meet Mavis in the clinic to discuss the situation.

Mavis asked him about his own experience of mealtime when he was a child. The answer was not surprising: He had been forced to clean his plate. "If it was good enough for me," he stated, "it's good enough for my son." And how had he felt about mealtimes under those circumstances? Mavis asked. Mealtimes were unpleasant, the father admitted. Then, faced with the realization that his son was probably having similar feelings, the father agreed to let his son decide how much to eat at each meal (personal communication, Fall 1995).

In the feeding situation just described, parenting was clearly improved. Equally important but perhaps not as apparent is the observation that this improvement helps the two-year-old child during a developmental stage—separation and individuation—in which he is working to succeed at specific and necessary developmental tasks.

Feeding provides an opportunity for parents to support healthy development. By using Satter's division of responsibility and other healthy behavior related to the feeding relationship, a parent helps his or her baby to feel safe, secure, loved, and respected. These types of feeding behavior also help children to develop an internal sense of being capable, to experience and learn healthy boundaries, and to learn important life skills.

As with other aspects of parenting, the area of feeding is likely to present difficulty for parents.⁸⁻¹⁰ The struggle is usually expressed as frustration or concern about their child's eating behavior. Feeding interactions are influenced by the child's developmental stage and by the particular tasks required at each stage, and a parent may lack knowledge about normal childhood eating behavior or strategies available for developing specific, healthy feeding behavior. Driven by this lack of awareness, parents can have unrealistic expectations that introduce struggle into the feeding relationship. A child's emotional state and a parent's eating experiences as a child also can contribute to this struggle.

Infants, toddlers, and young children go through dis-

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tinct stages of development. Writing about failure to thrive and infantile anorexia, Dr Irene Chatoor noted how feeding struggles indicate struggles with the parent-child relationship in the first three stages of development: homeostasis, attachment, and separation and individuation.¹¹ What happens during feeding is vitally important to the child's emotional, social, and physical health. Knowing the child's age and current areas of development is helpful for interpreting the nature of the feeding struggle and for guiding an effective approach.

Feeding During Pregnancy

During gestation, a baby experiences a warm, moist environment that is for the most part secure, safe, and soothing. The physical boundaries are the tightest the child will ever enjoy, even as they change to exactly accommodate the unborn baby's growth. Little communication by the baby is needed to have his needs met for food, warmth, oxygen, and sleep.

During the second half of pregnancy, a new need and ability arise.¹² Babies begin to interact with their mother and with others. New evidence shows that they can hear and respond to singing, talking, reading, and noise; that they are aware of the touch of someone's hand; and that they can move in response to that touch. Researchers in brain development tell us that this healthy interaction helps to strengthen connections between neurons.^{12,13}

All in all, although the womb is an ideal and wonderful place to live, babies must develop into loving, capable people. To do so, they must be allowed to grow physically, emotionally, socially, and spiritually.

Feeding During Homeostasis

Homeostasis is the stage from birth to about three months of age. A parent's warm, responsive, consistent care at this stage helps the baby to contain the sometimes intense, frightening, and conflicting feelings that arise naturally from being out of the womb. Feeling safe and secure means being fed when hungry; being treated with respect by having feeding stopped when the baby gives cues of being full; sleeping when tired; being held, touched, and engaged when needing soothing interaction; and being given needed care. Dr Mary Ainsworth, a leading developmental researcher on the importance of the parent-child relationship, has said "... one of the reasons why feeding is interesting in the first three months of life is that the baby spends more of its time in interaction with its mother in the feeding situation than in any other kind of situation."¹⁴^{p169}

Dr Thomas Lewis and colleagues have written that this early interaction between parent and baby results in formation and storage of implicit memories.¹⁵ Some implicit memories formed by babies are based on their experiences in the mother's womb. Lewis et al¹⁵ state that these early implicit memories are powerful and become the basis for the child's definition of a loving relationship. These beliefs continue to guide each person's choices about love—even during the adult years. For example, the implicit memories formed by a young baby who is consistently fed with warmth soon after giving hunger cues are different from the implicit memories formed by a baby whose hunger cues are consistently ignored or who experiences unpleasant interaction during feeding. Dr Bruce Perry notes that this early interaction creates templates to which later experiences are compared.¹⁶

A fetus is fed without having to communicate about being hungry, but a newborn experiences a radical change from this life in the womb: Feeding and all other activities require the newborn to use sounds and body language to communicate his or her needs. A parent's responsibility is to observe this new form of communication, decipher what the baby is trying to say, and then fulfill the need being expressed. When the parent has solved the riddle and supplied the need, the baby feels understood, comforted, safe, and secure. Lewis et al have written:

Ainsworth observed ... that secure attachment resulted when a child was hugged when he wanted to be hugged and put down when he wanted to be put down. When he was hungry, his mother knew it and fed him; when he began to tire, his mother felt it and eased his transition into sleep by tucking him into his bassinet. Wherever a mother sensed her baby's inarticulate desires and acted on them, not only was their mutual enjoyment greatest, but the outcome was, years later, a secure child.¹⁵^{p75}

One gift health care practitioners can give parents is the awareness that the parent's care is powerful for the infant, who already has a genuine, deep connection with the caregiving parent. One example of this power is shown by a scene in the video "The First Years Last Forever": In this video, Dr T Berry Brazelton and a mother talk to a newborn simultaneously with approximately the same tone and loudness.¹⁷ The baby turns to the mother, clearly preferring her voice to Dr Brazelton's because the mother's voice, after all, is the voice the baby knows; she had been hearing it for months. Learning that the newborn recognizes and prefers the caregiving parent's voice can be a powerful experience for that parent.

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Feeding During the Attachment Stage

The theme of the next developmental stage—which occurs between two and six months of age—is falling in love: The parent and the baby fall in love with each other. This period is special and rewarding for both. By paying attention to cues given by the baby during feeding, the parent provides the responsive care that the baby finds so soothing. As in the homeostasis stage, the infant needs the experience of having someone be “crazy about” him or her and spending plenty of time showing it.

By about three months of age, a baby begins to smile at the parent, make noises at the parent, and watch the parent. The baby is experimenting—“trying out” both himself and his parents to learn whether they find him interesting.⁷ Major, long-lasting, life-affecting learning is taking place at this stage as the interaction and response of the parent creates in the baby an early internal belief about whether or not he or she is lovable.

Feeding offers a prime opportunity for parents to provide interaction that helps the baby learn that he or she is indeed lovable. In addition to nutritious food, parents can feed their love, care, and attention to the baby warmly, responsively, consistently. This kind of care helps to build an internal sense of being safe and loved—of having a “secure base.”⁴

Feeding During the Separation and Individuation Stage

This stage, at which an infant separates and individuates from his or her parent, extends from six months to 36 months of age and has three major themes: exploration, learning to be competent, and becoming one’s unique self. By this point, the relationship with his or her parents should have given the infant a strong, internal sense of trust. Toddlers who have this secure relationship explore their surroundings much more than do those who have been raised in an institution that is comparatively sterile emotionally.¹⁸ Exploring is a crucial element for learning—and learning is a skill essential for having a full and satisfying life.

A parallel effect exists for health care practitioners working with parents to explore their infants’ feeding behavior. We must build in these parents a sense of safety, security, and trust with us so that they will be more willing to take the risks involved in exploring their own feeding-related parental struggles and behavior.⁴

Issues of uniqueness and struggle continue to arise for parents: Each baby—and each caregiver—is unique. As babies mature, they reveal their unique food-related likes and dislikes and communicate them to the par-

ents. How parents respond to this uniqueness—whether they accept or reject it—will affect their baby’s sense of whether being one’s own, unique self is acceptable.

During this stage, a child’s task is to work on developing an internal sense of self, autonomy, and competence and to begin moving away from the closeness she has known; at the same time, the child still needs and depends on important relationships with his or her parents and other important caregivers. During this stage, the child seeks answers to some basic questions:

- Can I successfully explore the world and become more independent and competent while retaining my sense of connection to the important people who love me?
- Will the important people close to me let me learn to use my anger; allow and trust me to retain ownership of my feelings and behavior; and let me use the powerful word *No*?
- What kind of relationship will I have with my mother or father when I say *No*?
- What kind of relationship will I have with my mother or father when they say *No*?

Henry Cloud and John Townsend point out that three basic tools—anger, ownership, and *No*—help 18- to 36-month-old children to achieve the developmental tasks of this age.¹⁹ Cloud and Townsend state that a child learns from his or her anger that something must be addressed, and this skill is needed throughout life. Ownership gives a child an opportunity to take care of something (eg, a possession or an aspect of her life) that is necessary before she can genuinely start to share with others. Using *No* helps a child learn how to use power and how to maintain a healthy connection with another person while using or receiving *No*.

Cloud and Townsend¹⁹ state that being able to use *No* (verbally and nonverbally) is a very important life skill that will be used for the rest of the child’s life. The reactions of parents and other caregivers teach toddlers whether using *No* is okay or will cause them to pay a price for this behavior.

Psychologic Dynamics of Feeding: The Role of Parental Behavior

Feeding gives infants, toddlers, and older children an opportunity to practice using *No* by using a primary feeding relationship concept: division of responsibility. The child is thus allowed to be in charge of how much he or she eats of the food that is offered—and even whether the child eats at all.⁷ Feeding also gives a parent the opportunity to practice accepting the *No*.

More important, however, is the parent’s reaction

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when the toddler uses *No* by not eating a particular food or not eating any of the food. In general, parents react to this situation in one of three ways:

- by accepting and supporting the child's choice;
- by pressuring or forcing the child to eat the food; or
- by withdrawing from the child emotionally.

If a parent withdraws emotionally because of hurt feelings, the child learns that he or she will pay a price for using *No*: The child will lose his or her emotional connection to a very important person in her life. This consequence is a big price to pay. Parents who force their children to eat teach them that they will pay a different price: They will be treated with disrespect while experiencing the powerlessness of their *No*.

These parental responses teach a child that eating the food is more important to the parent than the child's feelings. The child learns that using *No* is not safe and that this *No* is likely to be ignored. This early, perceived lack of support for the child's use of *No* can adversely affect his or her use of and trust in this important life skill. In contrast, by allowing their children to refuse to eat certain foods or to refuse to eat when not hungry, parents give their children permission and support for acting in a way that shows love of self.

By accepting their children's refusal to eat a particular food at a particular time or their lack of a big appetite at a particular meal, parents send the message not only that using *No* is okay in this family but also that you can use *No* and still be loved in this family. This method of parenting is powerful because it builds within children a deeper sense of connection with their parents as well as internal beliefs that differ from those of children whose *No* is ignored or overridden. A child whose parents accept *No* will later be much more likely to feel comfortable saying *No* to something that is not good for the child.

Equally important, the division of responsibility provides an opportunity for the child to learn to accept *No*. When a parent allows the child to eat only at (and not between) snacktime and at meals, the parent is using *No* with the child. As Cloud and Townsend point out,¹⁹ children must learn to accept *No* from a parent while maintaining a healthy relationship with that parent. Of course, developing this acceptance and its associated behavior takes repeated practice; it cannot be learned overnight.

Other Challenging Situations Related to Feeding

Children who have been victims of abuse or neglect—or both—often have problems with food. Foster parents and other caregivers of such children can use feed-

ing time to develop with them a relationship that helps them to trust adults while learning that the children's likes and dislikes are respected. Through an appropriate feeding relationship, abused children aged 18 months to 36 months—and even older—can thus learn that their independence and competence are supported and encouraged by a healthy relationship with a wise, caring adult.

Children with diagnosed disabilities also benefit from a good feeding relationship with a caregiver. Children born with phenylketonuria (PKU) require a diet low in phenylalanine. The caregiver must teach the child what foods he or she can and cannot eat. Within this framework, the child will dislike some foods and thus will have an opportunity to use *No*. At the same time, the caregiver has the vital opportunity to interact with the child while learning, together with the child, what foods are appropriate for the child to eat. Working with parents of children with other medical conditions that frequently require clinical intervention (eg, cystic fibrosis, Down Syndrome, HIV/AIDS), health care educators can help these parents to recognize their children's special dietary concerns and thus encourage attachment behavior.

How Health Care Staff Can Help Parents

When collecting and assessing a child's nutritional status and other health information, health care practitioners—who naturally desire to help the child—often focus more on the child and his or her “nutrition problems” than on the parent's reaction patterns. But having capable, loving parents is the key to being a healthy child; and therefore staff are more likely to have a positive impact on the child if they have a positive impact on the parent. In a recent national survey, 79% of parents said that they want more information and support in one or more of six areas of childrearing.²⁰

Ellyn Satter has noted how parents need to feel that staff are on the parents' side, support them as parents, and are competent in their work.⁷ Thus, a helpful strategy is to remember four key parental desires:

- to have happy, smart kids;
- to be seen as experts on the subject of their own kids;
- to be seen as acting in their kids' best interests; and
- to make parenting as easy as possible.

Before clinicians can expect improvement in a parent's feeding behavior, the clinician must do three things: identify the parent's needs with regard to his or her child's eating; partner with the parent to share knowl-

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edge about normal childhood eating behavior; and help the parent to resolve his or her needs through use of appropriate feeding behaviors.

This approach—focusing on the feeding relationship—offers an excellent opportunity for health care practitioners to connect with parents to identify their needs and help meet them. The experiences of revealing a feeding struggle, receiving competent help, being treated respectfully, and successfully resolving that struggle can help parents to feel more loved and thus open the way for them to give more genuine love to their children.

A child's eating behavior may be an appropriate starting point for our approach, but our work is mainly with the parent and with his or her feeding behavior—and one important feeding behavior is how parents offer new foods to their children. The idea is simple: New foods enable parents to provide variety, which is critical for nutritional health. Implementing this idea, however, is complex because many factors influence whether a child eats (or even tries to eat) the new food. Such factors include the normal toddler behavior of using *No*; the child's environment during mealtime or snacktime; the child's level of hunger; and the parent's feeding behavior.^{5,21} Aspects of the child's uniqueness—for instance, his or her level of sensitivity to bitter flavors—can be a factor.^{22,23}

Offering a new food can be reframed in a way that connects it with the parent's desire to act in the child's best interests. Because parents want their children to be able to cope with the challenges that they will inevitably face in life, health care practitioners can suggest to parents that offering a new food is a double opportunity, ie, for the parent to provide a small, limited challenge to the child and for the child to handle the challenge in a way that fits his or her temperament. Nutrition educators can reassure parents that their children may be somewhat uncomfortable with new foods but that this discomfort is normal and that the offer of a new food is a genuinely loving gift given to a child.

By reassuring the child face to face in a nonintrusive, matter-of-fact way and not trying to resolve the child's discomfort, the parent lets the situation be the child's own challenge. The child thus receives two gifts:

- the opportunity to cope with a limited challenge at the child's own pace; and
- the reassuring presence of a caring parent.

Meanwhile, this behavior also gives the parent two gifts, both in the form of knowledge:

- the knowledge that his or her parenting will help the child grow up capable and confident; and

- the knowledge that this way of parenting provides an important behavioral model—that of supporting a loved one who is struggling with a problem.

These gifts are manifestations of powerful parenting.

Parents who are unable to follow this approach may benefit from exploring the underlying reasons for this inability. Like the father in Mavis Bomengen's story, some parents may have eating experiences from their own past that affect how they feed today. A primary prevention setting is not the appropriate milieu for in-depth examination of the parent's feeding struggles, but the parent should be allowed to speak the truth, to let natural and helpful feelings arise, and to connect the parent's own feeding behavior with his or her own childhood eating history.

An alternative is for the health care practitioner to offer a thought-provoking question, for example, "I wonder if you had any eating experiences earlier in your life that might be contributing to this struggle you're having? I don't know if there are or not; I'm just wondering about it." Letting the parent leave the visit with an unanswered question can be both a respectful and an effective way of acknowledging that the parent may not yet have a sufficient sense of safety and trust to explore a feeding-related issue. The health care practitioner thus leaves the parent with the feeling of having had an overall positive experience despite struggling with a feeding-related problem.

Conclusion

Feeding is the area of a child's life where nutrition, parenting, and human development meet. Health care practitioners need not only nutrition knowledge but also the knowledge of how parenting and development each contribute to the parent-child feeding relationship. Exclusive focus on the type and quantity of food a child is eating results in failure to notice specific parenting behaviors that affect the child's eating; and this failure decreases the opportunity to improve the child's nutritional status.

Much more than nutritious food can—and should—be provided during breastfeeding and at other feedings. Feeding provides an opportunity for parents to be present with their children and to give them love, care, and attention. Researchers in early childhood development and brain development emphasize that this interaction is a powerful gift that affects the health of the child.²⁴ Feeding assumes this broader role by affecting not only the child's physical health but also his or her social and emotional health. Each mealtime provides interaction between parent and child, and each interaction is filled

with potential. Helping parents to incorporate healthy feeding behavior into mealtime offers a substantial opportunity for health care practitioners to support the healthy physical, emotional, and social development of many infants and young children.

Anyone who routinely works with parents and children encounters families in which a parent and child struggle with their relationship. Helping the feeding relationship to proceed constructively helps the parent-child relationship to proceed constructively and builds genuine love in—and for—the parent. This love is what produces parents' genuine desire and effort to help their children thrive. ❖

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Each mealtime provides interaction between parent and child, and each interaction is filled with potential.

Hunger

I'd like to have my hunger understood
to be so literal to be suspicion-free
you can't see, touch, or hear what's really missing in me
so I can't explain it
but believe me
I am hungry.

— "Gapped" by Pamela Sackett, poet and founder of Emotional Literacy Advocates™