

MAMÁ, NO QUIERO MAS: LOOKING AHEAD IN THE REMEDIATION OF FEEDING DISORDERS IN HISPANIC INFANTS

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Abstract

Disorders in infancy and early childhood are now understood to be complex and involve the factors of maturation, attachment, and family environment (Zero to Three, 2007). Feeding disorders in these developmental stages have a higher level of complexity, incorporating cultural factors as well. The failure to thrive resulting from these disorders eventually leads to both physical and cognitive decline in children (Chatoor, Surlles et al., 2004). Research has consistently shown that a multidisciplinary treatment approach, with the family being central in the process of treatment, results in improved outcomes for children (Chatoor et al., 1992; Greer, Gulotta, Masler, & Laud, 2008; Piazza & Addison, 2007). Despite successes in the treatment of infant feeding disorders, Hispanics have disparities in finding culturally competent providers who speak Spanish and are intimately aware of cultural family dynamics (Flores, Olson, & Tomany-Korman, 2005; Howell & McFeeters, 2008; Malgady & Zayas, 2001). Additionally, Hispanic families have differing parenting styles when in a feeding situations than when in typical social settings (Cardona, Nicholson, & Fox, 2000). With these significant disparities existing in the delivery of services and the particular characteristics exhibited by Hispanic families in feeding situations, the need for programs that treat infant feeding disorders within a cultural context is imperative.

Keywords: Health disparities, Hispanic, infant feeding disorders

Introduction

Children, particularly young children, are fast becoming the largest group of individuals seeking mental health services. Prevalence rates in the identification of social and emotional problems in infants and young children range between 5 and 35%, almost mirroring the rates for school aged children (Evangelista & McLellan, 2004). Even more startling is that over 2 million infants and toddlers in the United States are considered “at risk” for

an eventual mental health disorder (Zero to Three, 2007). Among the most debilitating disorders for children at this age level are the feeding behavior disorders, in which the normal regulation of the physiological functioning of feeding is not achieved (Zero to Three, 2005). Such feeding problems can begin as early as birth, with difficulties in sucking and choking during feeding (Motion, Northstone, & Emond, 2001). Biological, behavioral, social, emotional, familial characteristics and their interaction ultimately produce a series of inappropriate feeding and ingestion styles in infants and toddlers.

The social and emotional needs of such children are at even greater risk when socio-economic status, racial and ethnic differences are added to the mix (Hurley, Black, Papas, & Caufield, 2008). Several studies have found support for the idea that mental health disparities exist, particularly in the Hispanic population (Flores et al., 2005; Howell & McFeeters, 2008; Malgady & Zayas, 2001). Malgady and Zayas cite that a particular issue impacting the disparity of mental health seeking behaviors in Hispanics is the need for bi-cultural mental health programs with bi-lingual providers. Flores et al. found that only a minority of African American and Hispanic children received care from a provider that was from their own cultural background.

The inability for Hispanic individuals to communicate in their own language and express cultural idioms of distress, negatively impacts the diagnostic process and, ultimately, the treatment of a disorder. Howell and McFeeters (2008) found that Hispanic children in both urban and rural locations received less mental healthcare than their African American counterparts. This difference was more likely due to the lack of culturally knowledgeable providers in both urban and rural settings for Hispanic children, therefore limiting parents on the availability of qualified services (Howell & McFeeters, 2008). In having less access to culturally trained professionals and programs, psychopathology worsens in adults, decreasing the quality of parenting behaviors and increasing risk for their children (Zero to Three, 2007). This disparity among Hispanic adults ultimately turns into a disparity for Hispanic children as well. All the studies above provide conclusive evidence for the need to provide culturally and empirically based treatments for the mental healthcare needs of children between the ages of birth to three years and their families.

A key issue in children with feeding disorders is their failure to thrive. Persistent failure to thrive due to these feeding disorders ultimately impacts the cognitive development of infants and toddlers. Using a multidisciplinary approach, Chatoor, Surles et al. (2004) found that psychosocial factors have greater consequences on cognitive development than nutritional factors alone. Chatoor, Surles et al.'s study provides

compelling evidence for a treatment approach that directly targets these psychosocial factors in parents.

Society is at a crucial point right now regarding the mental healthcare needs of Hispanic children between the ages of birth to three years. The Zero to Three: National Center for Clinical Infant Programs has suggested that the US Congress provide comprehensive legislation that will allow for programs to be developed in this area (Zero to Three, 2007). The organization adds that particular attention should be placed on increasing the knowledge base and access to mental healthcare for young children among a variety of ethnic and cultural minorities (Zero to Three, 2007).

The purpose of this review is to identify possible solutions for Hispanic families to ameliorate infant feeding disorders. Many terms and issues have surfaced over the years relative to this topic and such concepts, including overall infant development, the process of infant mental health and impact on feeding disorders as well as health disparities for Hispanics in the U.S. Additionally, it is important to consider the variety of feeding and parenting styles that occur within the Hispanic culture will allow for a broader understanding of the impact of feeding disorders in Hispanic families. The need for further resources, for children, parents and practitioners working with infant feeding disorders is of utmost importance in such a discussion.

Feeding Disorders of Infancy

Historically, eating disorders have been viewed as a series of complex diagnoses in adult psychopathology that developed from family and individual factors. In diagnosing children with an eating disorder based on the *DSM-IV* criteria, clinicians have few subtypes and criteria that do not necessarily consider all aspects of infant development (Kerwin & Berkowitz, 1996). There is a growing body of research however, suggesting that infants and children meet criteria for eating disorders, particularly relating to emotional dysregulation (Zero to Three, 2007). These disorders are further classified into such categories as state regulation (difficulties maintaining an appropriate emotional state for feeding), food aversions, and difficulties in social reciprocity with a caregiver (Zero to Three, 2005). These classifications are particularly effective in the diagnosis of infant feeding disorders, which have a variety of environmental and biological effects.

Scheer, Dunitz-Scheer, Schein, and Wilken (2003) tested the efficacy of the *DC: 0-3* in diagnosing feeding behavior disorders in clinical populations. Using a sample of 93 infants (from 3 weeks to 38 months) referred to their treatment program for post traumatic feeding disorder, the authors provided the infants with treatment modalities tailored to their needs (Scheer et al., 2003). The authors found that several of the children who had

multiple medical procedures done had displayed avoidant attachment styles toward their parents (Scheer et al., 2003). Assessments using the DC: 0-3 infant feeding disorders criteria were successful in further streamlining interventions, limiting the need to further traumatize children (Scheer et al., 2003). This suggests that the DC:0-3 is a powerful diagnostic tool in treating even the most severe feeding disorders.

Pathophysiology and inappropriate physical development may also be causes of infant feeding behavior disorders. These studies correlate to the *DC: 0-3R* diagnosis of feeding disorder associated with concurrent medical conditions (Zero to Three, 2005). Field, Garland, and Williams (2003) proposed that there were discrete, physiological correlates to childhood feeding disorders and that these conditions were also associated to specific feeding problems. Children with developmental disorders showed the highest predisposition of displaying feeding disorders, while medical conditions associated with motor type feeding problems, including dysphagia (Field et al., 2003). Johnson and Harris (2004) found support for the idea that biological factors are related to the later development of feeding problems in childhood through their work with mother-infant dyads from the United Kingdom. Results found that previous illness correlated to higher scores of food refusal and neophobia than toddler temperament or feeding environment (Johnson & Harris, 2004). Johnson and Harris concluded that this is evidence for a “cyclical” pattern with feeding problems in infancy. Illness begins the problem; parents then change their behavior towards the child’s food refusal, increasing the child’s refusal behaviors (Johnson & Harris, 2004). The main caveat in these studies is the difficulty in identifying whether feeding disorders are a product of the underlying developmental or medical condition or if they are the result of a complex interaction of factors.

Chatoor (1985) suggested that a strong correlation existed between parent-child interactions and the ultimate development of a feeding disorder. In this crucial study, she identified three major components of failure to thrive associated to feeding disorders: homeostasis, attachment, and separation/individuation. While homeostasis and separation/individuation were based largely on biological and maturational mechanisms, Chatoor (1985) expressed that attachment has particularly emotional effects on infant feeding behaviors. This study was instrumental in both the fields of attachment and infant feeding disorders because it chronicled specific physiological and emotional components to feeding disorders.

Three different types of feeding disorders have been identified based on parental personality factors and on the quality of infant-mother interactions (Chatoor, 1985; Chatoor et al., 1997; Chatoor, 2005). First, feeding disorders of homeostasis, involving a deregulation in the internal balance of feeding (Chatoor, 1985). Parents of these infants tend to be overly

anxious, have high psychosocial stress and have poor reciprocal behaviors of attachment with their infants (Chatoor et al., 1997). Second, feeding disorders of attachment, involving an overall lack of emotional reciprocity between mother and infant, with parents exhibiting significant psychopathology (Chatoor, 1985; Chatoor et al., 1997; Chatoor, 2005). The last and most severe type of feeding disorder, infantile anorexia, has the component of failure to thrive and psychosocial dysfunction (Chatoor, 2005).

Chatoor and colleagues repeatedly found evidence for the idea that disruptions in infant feeding would affect their physiological mechanism of eating (Chatoor, Conley, & Dickenson, 1988; Chatoor, Ganiban, Harrison, & Hirsch, 2001; Chatoor, Ganiban, Surlis, & Doussard-Roosevelt, 2004). Infants exposed to traumatic medical procedures (e.g. feeding tubes, invasive surgeries, etc.) had higher instances of choking, food refusal and negative patterns of eating (Chatoor et al., 2001). Chatoor, Conley et al. explained that these procedures had both psychological and physiological effects, where the child was unable to feel the sensations of hunger or satiety. Further Chatoor, Ganiban et al. found physiological differences (e.g. fast heartbeat, respiratory arrhythmias, etc.) between children diagnosed with infantile anorexia and control groups. The infant's homeostatic eating balance is altered, providing for an increased risk of disordered eating.

Subsequent studies continued to find support for the hypothesis that infant feeding disorders are rooted on problems of attachment (Chatoor, Egan, Getson, & Menvielle, 1988; Chatoor, 1989; Chatoor, Hirsch, Ganiban, Persinger, & Hamburger, 1998; Chatoor & Ganiban, 1998; Chatoor & Ganiban, 2000). Among the most prominent findings of these studies, the authors report that infants with feeding disorders displayed less reciprocal social behaviors, more conflict when exposed to infant-mother situations and more struggle for control (Chatoor, Egan et al., 1988). Further, infants attempted to gain a sense of control over their immediate surroundings via food refusal and poor eating behaviors (Chatoor, 1989). Further aggravating the situations of control and conflict were the factors of maternal emotional availability, parenting style and sense of control during feeding times (Chatoor, Egan et al., 1998; Chatoor & Ganiban, 1998). A detrimental cycle of food refusal and inappropriate parenting behaviors during feeding ensues, leading to both parental frustration and, ultimately, an infant feeding disorder (Chatoor & Ganiban, 2000).

Several studies have found similar results as Chatoor's on the use of an emotional framework to conceptualize infant feeding (Benoit, Madigan, Lecce, Shea & Goldberg, 2001; Feldman, Keren, Gross, & Tyano, 2004; Hagekull, Bohlin, & Rydell, 1997; Hurley et al., 2008; Wiefel et al., 2005). While having long term effects as well, the complex interplay between maternal sensitivity and infant temperament can immediately be seen in

infant feeding problems (Hagekull et al., 1997). Mothers who are experiencing high levels of stress or pathology also have a nonresponsive feeding style, an interaction that is of utmost importance in infant development (Hurley et al., 2008). Further, children diagnosed with a feeding disorder and their mothers display a significantly low level of emotional availability, even below that of the interaction between mothers and children with externalizing or aggressive disorders (Wiefel et al., 2005). Overall, attachment has a significant impact on appropriate infant feeding behaviors and interventions targeting the improvement of attachment behaviors will also improve infant feeding disorders (Benoit et al., 2001).

Treatment Modalities

The studies above clearly demonstrate that, rather than a function of an infant's biology and temperament alone, infant feeding disorders are grounded in the reciprocal behaviors, emotions and interactions between parents and children. It is even more difficult to tell when the problematic cycle begins because the interaction, not the parent or the child, becomes the most damaging component (Lieberman & Van Horn, 2008). While this disorder may not directly involve a child's feeding schedule, the parent's behavior may impact non-feeding environments (playtime, bath time and even bedtime) that are regarded with equal importance to the child (Hurley et al., 2008). As the quality of the relationship deteriorates on these circumstances, it will hamper the proper development of feeding behaviors (Chatoor, 2009).

In terms of the prognosis of a feeding disorder, the type of behavior displayed also impacts its treatment outcome (Fischer & Silverman, 2007). It can be suggested that the rigid and stereotypical behaviors involved in the diagnosis of autism can lead a child to develop a routine around certain foods and refuse others. This can further aggravate the existing feeding disorder and negatively impact its treatment. In contrast, a child who is less rigid in his or her behavioral style, despite having a feeding disorder, may benefit more from treatment and have a better prognosis (Fischer & Silverman, 2007). Behavioral interventions, focusing on such factors as a child's behavioral style and parent feeding behaviors, have shown promise in treating feeding disorders of infancy (Benoit & Coolbear, 1998, Fischer & Silverman, 2007; Reed et al., 2004).

Other studies have supported the idea that even simple feeding problems (slow or selective eating, fussiness during mealtimes) should be treated before they develop into a larger disorder (Hutchinson, 1999). This is because these feeding problems usually accompany parental anxiety and control behaviors that impact both the physical and emotional development of their children (Hutchinson, 1999; Locklin, 2005). Multidisciplinary

approaches, including pediatric, nutritional, and psychiatric interventions for the children, and parental support and training, have shown the most effective results (Fischer & Silverman, 2007; Greer et al., 2008; Hutchinson, 1999; Piazza & Addison, 2007; Reed et al., 2004).

Behavioral Treatments

A series of authors have identified specific behavioral factors involving feeding disorders including fear of food and feeding, due to associations made with such aversive feeding situations (Benoit & Coolbear, 1998, Fischer & Silverman, 2007; Reed et al., 2004). A consistent finding among all authors in the behavior therapy domain for feeding disorders was the use of a three pronged treatment approach involving: identifying hunger and fullness cues, nutritional monitoring, and behavioral flooding (Benoit & Coolbear, 1998, Fischer & Silverman, 2007; Reed et al., 2004). These studies further hypothesize that food refusal in the child elicits a chain of negative reinforcement (Hoch et al., 2001; Patel et al., 2002). The child has a problematic experience with the food and refuses the food at the second presentation. The parent, becoming anxious about the food refusal, no longer presents the food to the child, further increasing the food refusal behavior (Patel et al., 2002). Hoch et al. found that positive reinforcement, not continued presentation of the food alone, was successful in reducing food refusal behaviors. A concern in these studies, however, is their reliance on positive reinforcement alone to increase food consumption.

With such a large variety of physical, emotional and psychosocial variables involved in the development of infant feeding behavior disorders, it may be difficult to effectively implement and monitor behavioral treatment approaches in daily settings. Linscheld (2006) suggests that while such studies show that behavioral techniques are effective in ameliorating infant feeding disorders, there is difficulty applying these results to the real world. Linscheld also suggests that there are a variety of elements that are difficult to manage and control in the general population. While it is easy to monitor nutritional guidance and medical protocols in a research study, these variables often change in a real world setting (Linscheld, 2006). These are situations which lead to changes in the child's behavior and ultimately, decrease the efficacy of treatment in real life. Linscheld concludes that research and real world interventions must mirror each other in assessment, treatment and monitoring for true changes to take place in clients with infant feeding disorders.

Multidisciplinary Approaches

Families, particularly parents, are seen as the core of treatment for infant feeding disorders (Chatoor et al., 1992; Greer et al., 2008; Piazza &

Addison, 2007). Beginning with thorough assessments including medical, nutritional, motor, and psychiatric development, the multidisciplinary approach further considers parental factors, such as stress and anxiety, children's individual temperament styles and control issues (Chatoor et al., 1992; Greer et al., 2008; Piazza & Addison, 2007). While these studies undertake a multidisciplinary approach to therapy, involving nutritional and medical components, the core component is the education and training of parents in techniques that will enhance the bond with their children and improve the overall emotional development of the child.

In this therapeutic modality, parents are provided with schedules of feeding to help the children identify hunger cues (Chatoor et al., 1992). Parents are also asked to model appropriate eating behaviors and decrease their own emotional reactions to inappropriate eating behaviors (Chatoor et al., 1992; Greer et al., 2008). Additionally, based on functional assessments necessary in this treatment modality, differential diagnoses can be made between children who are exposed to traumatic experiences related to feeding (Post Traumatic Feeding Disorder of Infancy) or those who have no past traumatic history (Piazza & Addison, 2007).

While a number of studies have been completed with clinical populations (Chatoor, 1985; Chatoor, Egan et al., 1988; Chatoor et al., 2001; Chatoor, Ganiban et al., 2004; Chatoor et al., 1992; Chatoor, Surles et al., 2004) the current empirically supported treatment program for infant feeding disorders specifically targets children who do not have an underlying medical illness (Chatoor, 2005; 2009). According to Chatoor (2005), failure to thrive is a direct result of decreased food consumption due to being easily distracted by external stimuli and interest in play. These children tend to have eaten well in earlier months of life (birth to about 9 months), but when beginning to self feed, they lose their ability to regulate their feelings of hunger (Chatoor, 2009). The compensatory behaviors parents establish to deal with their children's lack of eating establish and continue to maintain this unhealthy pattern (Chatoor, 2009). Due to this, parents are intimately involved in the process and learn about their child's individual temperament characteristics, parental difficulties balancing nurturance and limit setting and the conflict that arises during feeding situations (Chatoor, 2005; 2009). Ultimately, support for the parents is crucial in this treatment modality, since much of the treatment involves emotionally targeted behaviors and situations.

Challenges with Hispanic Families

The etiological and treatment studies outlined above focus on white non-Hispanic or European cultures. When addressing infant feeding disorders with Hispanic families, a new set of challenges arises. Healthcare

disparities, particularly among the Hispanic population, limit both the services and the number of culturally competent professionals that are available to treat medical and psychological disorders within this culture (Flores et al., 2005; Howell & McFeeters, 2008). Additionally, a parent's cultural view of mealtimes, belief systems and socialization during these situations is directly transmitted to their child through their interactions (Gomel & Zamora, 2007; Hughes et al., 2006; Matheson, 2008; Patrick, Nicklas, Huges, & Morales, 2005). In order to address infant feeding disorders in the most culturally competent manner, it is imperative to understand the parenting styles and beliefs regarding mealtimes and behavior in Hispanic families (Hughes et al., 2006; Matheson, 2008; Patrick et al., 2005).

Cross cultural research regarding differences in Anglo American and Hispanic parenting styles has shown a higher degree of discipline and lower nurturing behaviors in Hispanic parents of children between the ages of 3 to 5 years (Cardona, Nicholson, & Fox, 2000). Discipline is used by Hispanic parents to obtain more control over their children's success in society (Cardona et al., 2000). During mealtimes, however, Hispanic parents tend to report more permissive, indulgent parenting styles (Hughes et al., 2005; Hughes et al., 2006; Hughes et al., 2007). Both overly restrictive and overly indulgent parenting styles have been shown to be risk factors for infant feeding disorders (Patrick et al., 2005). Moving Hispanic parents toward a more authoritative parenting style overall will improve the child's feeding behaviors and decrease parental anxiety (Patrick et al., 2005).

The definition of nurturance in Hispanic families is important in terms of treatment modifications for infant feeding disorders. Studies on Hispanic family dynamics and socialization have found that Hispanic mothers are more open to verbal and physical expressions of affection than White, non-Hispanic mothers (Zayas, 1994). Additionally, Hispanic parents use meal times to support the emotional nurturance of their children (Hughes et al., 2006; Hughes et al., 2007; Matheson, 2008). Meals are associated more with their roles as mothers or fathers, than with the nutritional value of food and its health effects (Gomel & Zamora, 2007). Hispanic parents also identify secure attachment in different terms than their Anglo-American counterparts (Zayas, 1994). While Anglo-American mothers view securely attached children as more independent and autonomous, Hispanic mothers consider affection, respectfulness and responsiveness towards adults as a secure attachment style (Zayas, 1994).

The power struggle that ultimately ensues between the mother and child is a main factor in the etiology of infant feeding disorders (Chatoor, 2009). Treatment involves an entire restructuring of parenting styles and views on child behavior (Chatoor, 2009). Hispanic parents are more

accepting of behavioral techniques, such as response cost or punishment versus those using positive reinforcement (Borrego, Ibanez, Spendlove, & Pemberton, 2007). The use of a traditional, non-Hispanic protocol for infant feeding disorders implies that parents must change their cultural view of attachment, thus limiting its effectiveness. Modifying the protocol to include the definition of attachment and parenting styles among Hispanic parents would provide an improved prognosis for Hispanic families.

Conclusion

The treatment of infant feeding disorders within a cultural framework has an impact in various areas of functioning. The interactive nature of most infant feeding disorders suggests that these disorders have their greatest impact on the attachment process, which is begun at birth (Chatoor, 1985). Culture engulfs this attachment process and guides parents in their efforts to form bonds with their children. When working with the Hispanic culture in particular, parents stress an authoritarian parenting style overall, yet during mealtimes they will use more permissive styles to feed their children (Cardona et al., 2000). As the culture identifies food as a method of nurturance, feeding situations become increasingly important in the parent child relationship.

In addition to the difficulties of treating the disorder within the view of the Hispanic culture, there are several factors which create disparities in mental health for Hispanic individuals. Hispanic clients often have disabilities in communicating in their own language with their therapists (Howell & McFeeters, 2008; Flores et al., 2005; Malgady & Zayas, 2001). Many therapists, while understanding the Spanish language, are unfamiliar with cultural idioms of distress crucial to the understanding of a disorder. Ultimately, Hispanics have less access to culturally trained professionals and programs (Howell & McFeeters, 2008; Flores et al., 2005; Malgady & Zayas, 2001).

Clinicians currently have a wide variety of treatment choices and differential diagnoses with regards to infant feeding disorders (Chatoor, 2009; Reed et al., 2004; Greer et al., 2008; Piazza & Addison, 2007). Many of these treatments, however, are not tailored to the emotional needs or cultural beliefs of Hispanic families (Gomel & Zamora; 2007; Hughes et al., 2006; Matheson, 2008; Patrick et al., 2005). With the large discrepancies existing in the availability of clinicians and treatment modalities for Hispanic families (Flores et al., 2005; Howell & McFeeters, 2008), there is a clear need for a comprehensive, multidisciplinary treatment for infant feeding disorders in Hispanic families.

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