FOCAL PLAY-THERAPY AND EATING BEHAVIOR SELF-REGULATION IN PRESCHOOL CHILDREN

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Introduction

Clinical experience teaches us that, in general, nothing touches parents emotionally so deeply as the problems they have with their children, particularly those relevant to eating which they often try deal with best in every way. The family is a unit in which relationships (both dyadic and triadic) are established which should be characterized in terms of alliance. The child and the parents are part of a totality in which, on the one hand, each has regulating and interactive abilities and, on the other, the various members influence and regulate each other reciprocally. The contribution of the parents is fundamental because the initial ability of the child to self-regulate its own emotional state and therefore its behavior, is immature and limited.

The pre-school period should involve the passage from the dyadic regulation of the first period of childhood to the self-regulation of the child outside the matrix of the caregiver (Sroufe 1995). The child is allowed to manage itself as far as possible. The balance between self-regulation and external regulation can therefore, over time, only shift in favor of the former when the child develops a greater ability to be responsible for itself, which increases both its own well-being and family harmony. As the child matures, however, the parents do not always do what is necessary to satisfy the child needs and to sustain a sense of Self as agent in the child. As a result, we may find ourselves facing a clinical population consisting of child/parent relational problems which express themselves through various behavioral modalities such as difficulties concerning eating behavior.

In the second year of life, when the child expresses the motivation to act of its own accord when eating, a desire to self-regulate its own behavior by establishing a direct and autonomous relationship with the food becomes apparent. The child is simply focusing on the "I'll do it" request, which the family can encourage with emotional support but can also render conflictual. It is relatively easy for a certain degree of conflict to arise when the child begins to gain understanding of the self and of others as independent agents. As part of the development of its own autonomy and of the movement towards self-regulation, the child must preserve his/her own internal goal even this contrasts with that of the caregiver. Direct challenge or passive non-adjustment may result as a consequence.

According to the Lichtenberg (1989) motivational system theory, the motivation to act by oneself is part of the exploratory-assertive motivational system but it is only related to the aversive motivational system when the child is forced to signal a lack of correspondence between his needs and the caregiver's behavior. When the child effectively becomes a family member receiving the same esteem as the other members of the family, a common harmonious life is made easier in which behavior lead by the motivation to do by oneself is coherent with the feeling of being "I" but also part of "We". In this case, the motivation to do by oneself is congruent with the need to be

well integrated in the harmony of family life. The impossibility of becoming part of the family life reality without dissention because of coercive adult intervention can cause the child to feel painfully isolated. As a consequence, this can provoke psychosomatic protest behavior which signals both the need to regain lost autonomy and that the caregiver's behavior is inadequate. Although signaling the need for autonomous behavior, the psychosomatic protest behavior is also a sign of the child's dependence on the adult who imposes the rules. An enormous focus on the adult is maintained and the child cannot reach the desired autonomy.

We have dealt with the psychosomatic protest eating behavior expressed, for example, by the vomiting or refusal of food, with the Focal Play-Therapy (FPT). FPT is a therapeutic method that was conceived to address psychosomatic protest behaviors of both an eating and evacuation nature (Trombini 1969, 1970). It follows Gestalt theory, taking into consideration the principle of natural order, the concepts of the field, of the reference and focus systems, and the relational modalities present in the field and the aspects assumed with respect to the frustrated needs of the child. It is pleasing to observe that, at the moment, concepts such as the relational approach of the field (Ferro 1992) and perceptive focus on the indications of the expressed child need (Lambruschi 2006), are taken into consideration in other psychotherapies as well, such as psychoanalytical and cognitive therapies.

The FPT technique can encourage the self-regulation of both eating and evacuation behaviors. It is founded on an organized starting point which has already been described in detail elsewhere (Trombini, Trombini 2006), and consists of a temporal sequence proposed by the therapist in which a plasticine child puppet carries out the same fundamental physiological functions as the child itself, first eating and appreciating the taste of the food, then evacuating with relief. Focal points of this method consist in highlighting independence features in the relationship both with food and with corporal contents and allowing the possible expression of an aggressive modality. A reference system which is different from that experienced in the family is therefore offered. The therapist (T) restores the natural "valence" (Aufforderungscharakter) of the food, which is now shown as "something pleasant to put inside you". The focus therefore lies on the phenomenal quality of such stimuli and the child, pushed towards wanting to act on its own, can interiorize that which has been symbolized by T. This will thereby bring about the disappearance of the psychosomatic protest behavior.

The self-regulated eating behavior which emerges is emptied of the coercive aspects, and the child can feel happy in harmony with the family. During therapy, the development of a good emotional background is privileged because the classic insight can not be used with preschool children who have not yet developed this ability. The child, understanding that the therapist is interested in him/her, is encouraged to become interested in the adult's mind and in interactive modalities.

Today it is considered necessary to look at the environmental context of the child in its totality. It follows that intervening on the family rather than on the child by itself is the most effective therapeutic strategy in the preschool age (Sameroff 2004). We believe that it is essential to see the child together with its family members, using different modalities if necessary. The FPT has therefore been conceived to be carried out in an extended context which also includes the parents (Trombini, Trombini 2006). We

were inspired by the model of participating consultation proposed by Vallino (2002a, 2002b) which represents an occasion for both the parents to speak with the child and for the child to "speak" about itself with the parents present.

The meetings are structured around alternate play sittings with the child and the parents together and meetings with the two parents by themselves. An essential element of the setting consists of the parents being asked to concentrate their attention on observing their child's behavior during the play sitting, with the aim of discussing it afterwards with the therapist. In the context of this extended field, the FPT remains a psychotherapy for the child only and it does not constitute a family therapy or a therapy for the parents.

In the treatment of relational problems in the preschool age, the intervention strategy takes into consideration the premise that the continuity in disturbed individual behavior belongs to the system rather than being a characteristic of the individual. The causality of the problems is not therefore a characteristic of the individual subjects but rather, it is inherent in the relationship which is established inside the system (Trombini, Baldoni 1998). As a result, the behavior of the parents during the FPT can encourage or impede the therapeutic process. Behavior which encourages the process is characterized by tolerance, patience, collaboration, offers of support, proposals which are in line with the creativity of the child and trust and enthusiasm in the productivity of the child. Behavior which hampers the process is characterized by impositions rather than proposals, irrelevant or distracting interventions, lack of interest and self-exclusion.

The parents' positive behavior, which makes use of their own constructive parental abilities and experience, can be underlined by the therapist through an evaluation which appraises some of their relational interventions and can be strengthened through acquiring a greater ability to see things from the point of view of the child. This can all be encouraged both through the parent/therapist meetings and by the play sittings in which the parents have the possibility of seeing how the therapist behaves, especially with the child, and of discovering with relief how they can offer help themselves.

We believe that the FPT carried out in the extended context makes it easier to resolve the symptoms whilst promoting the well-being of the family. We know that in normal development, the growth of the child is encouraged by the efforts of the adults who are around it and who show an empathetic attitude towards it. In this explanation of our psychotherapeutic work we therefore wish to place particular attention on the parents' behavior because we believe that the process of self-regulation in eating behavior is not only made easier by the empathetic understanding and responsiveness of the therapist, but also by the understanding and responsiveness of the parents.

Clinical cases

The clinical cases of two children in the preschool age with eating behavioral problems will be presented and the behavior of the parents will be particularly highlighted.

The first case shows a type of parent behavior which mainly encourages the therapeutic process: the case of Marzia, which has already been extensively looked at in a previous work (Trombini, Trombini 2006), shall now be looked at again in the context of the profile outlined above.

The second case concerning Roberto, highlights a type of parental behavior characterized by aspects which hinder the therapeutic process and which is interrupted before allowing total self-regulation of the eating behavior of the child to occur.

First Clinical Case

Marzia's parents contact the therapist because their two-year and three-month old daughter shows eating problems: Mz has never eaten much, usually the same food, she is suspicious of new tastes and recently she has been vomiting during meals.

Breast feeding was very difficult and weaning succeeded when Mz was 10 months old. She has been attending day nursery since she was one year old where her lunches are regular and she only vomits when she is at home. The father (F) says: "It's only at home with us that she doesn't eat". The mother (M) adds that sometimes she could strangle her because Mz eats a little bit and then she doesn't want to eat anymore: "when pressed she eats a little bit more but then she closes her mouth, sometimes she spits the food out and frequently she ends up vomiting". A recent pediatric examination confirmed that her weight was within the norm and excluded organic cause for the vomiting.

It comes out that when she comes back home from the day nursery she has a 300 grams bottle of milk, then another one as an afternoon snack and another one before going to sleep because often she does not want to eat at dinner time. M is particularly worried since she recently saw Mz playing with a puppet and making it play and then vomit in the bin.

Mz's parents describe her as an active wild child ("she runs around in a crazy way…we are totally dedicated to her"), as a small tyrant who subjects her parents to her desires, especially during the long periods of play.

By eating little and refusing food, Mz creates arguments and disagreements between her parents concerning the strategies they should adopt. Mz. seems unable to play the role of "table-companion". M. says that she only eats for survival and her way of eating is not that of a table-companion, she would also like to go out with her daughter for dinner. The parents are worried about their daughter's health, they have already been worried in the past because of her premature birth, and therefore they force her to eat. Mz. is frustrated about not reaching her own independence in the eating area.

As far as the numerous bottles of milk are concerned, the therapist points out that from an eating perspective Mz. is treated like a baby. In this way she clearly shows the contrast between the baby and the table-companion and suggests a different eating modality: a more permissive modality could be adopted, proposing food without forcing Mz. and trying to make her stay at the table with them during dinner which is an important event to share together. It could also be possible that the bottles of milk satisfy her so much that she doesn't feel hungry at dinner time. They can help their daughter to have a better diet which is more appropriate for her age by choosing snacks that she likes and reducing the milk.

When T meets Mz with her P, T is able to immediately establish a good alliance with the child, leaving her time to explore the toys in the room. T therefore suggests Mz make a plasticine puppet (which she will then use for the FPT eating-evacuation sequence), which the child accepts enthusiastically. While the mother becomes

involved and gets into the play mood, the father comes in with a series of distracting speeches, wandering off the point. Mz therefore gets irritated and lies down under the table, staying there despite the fact that M implores her to come out. T decides to put herself on the same level as the child: she asks Mz through the plasticine puppet whether it can go to sleep with her. Mz gets up smiling and goes back to playing at the table. The FPT sequence is then suggested and Mz participates actively and with enthusiasm. While M collaborates offering to help construct the plates and forks, F cuts himself off. Towards the end of the meeting, Mz notices through the process of making the puppet eat and then evacuate, how she and M and T have dirtied their hands with plasticine.

Her final trick, consisting in dirtying her father's hands with her own (F smiles at this) and then inviting everybody to go to wash their hands as a way to form a group, is extraordinary.

During the sitting, Mz carried out the entire FPT eating-evacuation sequence, which she perceived with attractive valence and which was strictly related to her desire to self-regulate her own eating behavior. It should be noted that in relation to the positive alliance established between Mz and T, M's cooperation came first and F's only later.

The parents' energetic cooperation is intensified in the following sitting during which T can remain in the background. F appears more in tune with the situation, even if he intervenes in a distracting manner while trying to establish a direct link with Mz. The overall impression is that parents have become more capable of joining in with their child's initiatives and the perception is confirmed that as far as eating is concerned, a natural focus on the diet contents and pleasurable contact with them is re-established in an atmosphere of regained family harmony. The symptoms inherent in the eating behavior disappear quickly and this condition is confirmed again after one year. The syntony which became evident in play is now also present in other family behavior. For example, Mz accepts the news that M is expecting twins: she gives some kisses to her tummy but also some little smacks. When they are born, she expresses happiness and, naturally, also some jealousy.

Second Clinical Case

The parents (P) of Roberto (Rb) turned to the therapist because of the problems of their four-year old child: Rb has never taken pleasure in food, in order to eat he has to be fed and it can even take an hour and a half to finish the meal. Furthermore, he still wears his nappy (for peeing) both during the day and at night. It is the same at school, where Rb is shy and solitary. When he comes home, he sucks his cushion lying on his bed: the irritated M comments that "thanks to this his looses his appetite and doesn't want to drink". Rb is described by his parents as a child who plays repetitive games, putting the objects in a row and tying them to each other. The parents are exasperated by Rb's behavior and M underlines the fact that when he is given milk from the milk bottle in the morning, he won't hold it and lets his arms fall limp on the table, thereby expressing his passive protest. When the mother was sent to hospital to give birth to his little sister (who is now one year old), Rb feared that he would never see her again and as a result he became repeatedly seriously ill with bronchitis which forced him to stay at home away from school.

Right from the beginning, Rb gives the impression of being a child with an alert and curious eye, not shy at all, capable of introducing and continuing a narrative in a decisive, active, yet polite manner, which involves both M and F.

During the first meeting, Rb puts balls of plasticine on the lorry, which, he says, "look like meat-balls". The FPT is therefore proposed which the excited child carries out straight away by himself. M, however, immediately gets involved in the game and acts opposingly, asking him if she can have some food for herself. T has to intervene: "we are play-pretending that the little plasticine man has to eat!"

In the following meeting, Rb carries out some recurrent narrative ideas. He prepares food with which he fills up trains and lorries. He says of himself: "I am a waiter who carries cakes and sweets for M and F". Rb is a cook who prepares omelettes and who loves to eat cakes, but only towards the end of the sitting, after lengthy preparation. Rb is child/cook who models and controls, but, even if they try to be a part of the game, P interfere and weigh down on him. During the meetings M makes suggestions which are uncooperative with the creative intentions of the child. During the FPT, Rb also proposes other recurrent themes: rescue trains and fire-engines appear which put out the fires produced by the gas hobs. F intervenes mainly with intrusive behavior: he proposes his own themes such as sticking plasticine whiskers to his son's train. T comments: "it's as if each person wishes to carry out their own project." F replies: "everyone wants to play their own game. I behave like this with Rb almost on purpose" T underlines that it is important to reflect on the importance, when playing together, of trying to understand the aim of the other and to give the other the necessary time to express it. P's way of behaving comes from the idea they have of their educational role: their role as parent-guide is priority. But they also understand the need to change their behavior with respect to Rb. M sees herself as being more relaxed and more capable of tolerating the pace and rhythms of Rb. F spends more time with their son and remarks: "we should let him do things without discouraging him".

The family relationships and the eating behaviors improve: the parents allow Rb to eat at the table with his sister (and no more alone) and the child now eats with greater autonomy than he did before.

But during the fourteenth sitting, which is carried out alone with the parents, F surprises T with the sudden news that he wishes to end the therapy at this point. This seems to be linked to his idea that being a parent means that it is their duty to be the teaching guide. They say that they are very satisfied with the therapy and believe that they can continue to help their child by themselves. In the following and last meeting with Rb and P, the child, through the shower game which washes everything, communicates his perception of how much T has washed the anxiety of P and has supported and sustained his ability to "build a new railway, with a train which can be repaired, but which still needs time."

From the two clinical cases presented, the importance of carrying out the FPT in an extended context which includes the presence of the parents is confirmed. Our focus on their behavior allows us to observe how important the quality of parent behavior is in order to facilitate the self-regulation of the child's eating behavior and to enable it to participate in the life of the family "We" which is regulated according to the principle of respect.

The FPT in an extended context helps parents understand the child's interests expressed through [the] play and also its way of non-verbally expressing its desires, fears and angers. A child who refuses food is no longer considered by the parents as a mere body-organism that needs to eat and which is putting its health at risk. The eating behavior is not only considered at a concrete level and it is now possible to give it a psychological interpretation. Thus the context favors respect for the child's way of playing and the possibility of playing with it without assuming directive and intrusive positions.

Summary

The authors describe how to cope with child self-regulation difficulties in eating behavior using the Focal Play-Therapy (FPT). Following the Gestalt theory, the Focal Play-Therapy (FPT) has been conceived as a psychotherapeutic method for the treatment of eating and evacuation psychosomatic protest behaviors in preschool children. The FPT allows us to highlight independence features in the relationship with food and evacuation functions. The FTP is based on an organized starting point that allows the child to express its motivation to do by oneself through a self-regulated behavior that increases alliance with parents and family group integration.

The FPT privileges the development of a good emotional background because the classic insight can not be used with preschool children who have not yet developed this ability. The child, understanding that the therapist is interested in it, is encouraged to become interested in the adult's mind and in interactive modalities.

The FPT re-establishes the natural focus on food and corporal contents: in this way the therapeutic situation becomes a place where the child feels free to express a self-regulated behavior in a harmonic way with the family context. When it is possible, the FPT is conducted in an extended child-parent context. The extended context allows the therapist to observe the parents when they obstruct or block the play development with intrusive behavior and/or comments which are unrelated to the current situation and which express personal problems which can hinder rather than encourage the therapeutic process.

Furthermore, the clinical situations which we have observed show that the eating behavior problems can manifest themselves according to opposing relational modalities. Examples are presented of clinical cases, treated with FPT in extended context, which concern eating behavior difficulties in preschool children who express an active or a passive protest.

Zusammenfassung

Die Autoren beschreiben, wie unter Anwendung der Fokalen Spiel-Therapie (FPT) Schwierigkeiten von Kindern in der Selbstregulierung ihres Essverhaltens bewältigt werden können. Die Fokale Spiel-Therapie wurde nach Grundsätzen der Gestalttheorie als psychotherapeutische Methode zur Behandlung von psychosomatischem Ess- und Entleerungs-Protestverhalten bei Vorschulkindern entwickelt. Die FPT ermöglicht es, Aspekte des Strebens nach Selbständigkeit im Umgang mit der Nahrungsaufnahme und der Entleerungsfunktion zu beleuchten. Die FPT bietet dafür eine strukturierte Eingangs-Situation in der Therapie an, die es dem Kind ermöglicht, seine Motivation zum Selber-Machen eigenständig in selbstbestimmtem Verhalten auszudrücken und damit sowohl die Verbindung zu den Eltern als auch die familiäre Integration zu verstärken.

Die FPT legt großen Wert auf die Entwicklung eines guten emotionalen Hintergrunds; klassische einsichtsfördernde Vorgangsweisen, wie sie in der Therapie mit Erwachsenen üblich sind, können bei so jungen Patienten nicht angewendet werden, da Vorschulkinder die dafür erforderlichen Fähigkeiten noch nicht entwickelt haben. Indem das Kind erlebt, dass der Therapeut an ihm interessiert ist, wird es ermutigt, sich seinerseits dafür zu interessieren, was im Erwachsenen vor sich geht, und wird es sich auch auf ein interaktives Geschehen mit ihm einlassen.

Die FPT stellt den natürlichen Fokus auf Nahrungsmittel und körperliche Vorgänge wieder her: dadurch wird die therapeutische Situation zu einem Ort, an dem das Kind sich frei fühlt, sich selbstbestimmt und in harmonischer Weise im familiären Gefüge zu bewegen. Die FPT wird nach Möglichkeit in einem erweiterten Eltern-Kind-Setting durchgeführt. Dieses erweiterte Setting ermöglicht es dem Therapeuten, die Eltern zu beobachten, wenn sie z.B. das Spielgeschehen durch zudringliches Verhalten und/oder Bemerkungen behindern bzw. blockieren, die mit der gerade gegebenen Situation nichts zu tun haben, sondern ihre eigenen persönlichen Probleme sichtbar machen und den therapeutischen Prozess behindern, anstatt ihn zu unterstützen.

Darüber hinaus zeigen die von uns beobachteten klinischen Situationen, dass sich Probleme im Ess-Verhalten in Entsprechung zu gegensätzlichem Beziehungsverhalten zeigen können. Wir bringen klinische Fallbeispiele für die Arbeit mit FPT mit Vorschulkindern im erweiterten Setting, wo die Ess-Verhaltensprobleme aktiven oder passiven Protest zum Ausdruck bringen.

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