

SOME PSYCHOLOGICAL ASPECTS OF THE TREATMENT OF FOOD ALLERGY IN CHILDREN

By

WILLIAM KAUFMAN, Ph.D., M.D.
Bridgeport, Conn., U.S.A.

Certain normal and abnormal patterns of emotional reaction may develop when allergenic foods are eliminated from a child's diet. The key to successful long-term treatment of food allergies often depends on the proper clinical management of the child's emotional responses (a) to elimination of the allergenic food from his diet, (b) to the fact that he is different from other children, who do not suffer from food allergies; and (c) to his awareness that his tendency to have food allergies might have been transmitted to him from his parents.

The children I studied were boys and girls from 4 to 16 years of age; and the most common food-induced allergic ailments from which they suffered included those involving the respiratory, gastro-intestinal, dermal, cerebral and musculoskeletal systems.

An allergic child's emotional reactions to the initial knowledge that a specific food or foods will have to be eliminated from his diet for a prolonged period of time, and his subsequent reaction to the actual deprivation, depend on many variables. These include the age of the child, his emotional relationship to his parents, the character of his parents, whether or not his parents or siblings have food or other allergies, whether or not he is a well-behaved and obedient child, how independent he is in his thinking, how pragmatic he is in the formulation of his own judgments, the emotional significance

ance of the deprivation of the specific food or foods from his diet, the number and variety of foods to which he is allergic, the benefits he develops healthwise from his food deprivation, the loss of secondary gains he experiences as a result of his improved health—and the doctor's method of managing the total problem of the therapy of the child's food allergies.

On the one hand, the doctor must properly prepare the parents to understand the emotional problems of their child who is being deprived of allergenic foods, as well as their own attitudes toward him, and the problem implicit in his having food allergies. On the other hand, the doctor must help the child to understand within his capacity to do so the need for giving up specific foods and must give the child whatever psychological support he needs to succeed in this venture.

A child's normal emotional reactions to elimination of an allergenic food from his diet include four sequential stages which tend to merge into one another. These include (a) resistance, (b) tentative acceptance, (c) reality testing and (d) complete or substantial compliance.

Resistance. This is nearly always the child's initial reaction to elimination of an allergenic food from his menu. This is shown through his verbalizations, tears, tantrums and general disobedience; by his hunger strikes; and by his attempts to obtain and eat the forbidden food.

The therapeutic program should be set up in a kindly but firm manner. Parents should learn the nature of the child's problems in making an adjustment to his new way of eating, and should develop some insight into their own attitudes toward allergies and toward their own allergic child. They should learn to curb unduly punitive, harsh and overprotective impulses, and to substitute attitudes which are more appropriate. Each parent should spend more time playing with the child and giving him other forms of love, affection and understanding. Meals should be prepared to be interesting to the child, so he would be less likely to miss the allergenic food. Often it helps to have this food eliminated from the family's menu for a time. If the allergic child refuses to eat menus

which do not include the allergenic food, he is allowed to go hungry. Rather quickly, he will submit to the prescribed dietary regimen. If the eliminated food was an emotional security or reward food, every effort is made to have another food serve in this psychological capacity. When a child realizes that as a result of not ingesting the allergenic food he feels better, he usually accepts the new dietary regimen.

Tentative acceptance. After the stage of emotional resistance is terminated, the child will apparently be happy and contented when he eats a menu omitting allergenic food. This stage will last for weeks or months. But in time, he will develop a strong emotional need to test for himself whether or not eating the allergenic food will harm his health in any way.

Reality testing. In this stage, the child eats the allergenic food surreptitiously not so much to show defiance against medical or parental edicts, but instead to test for himself if it actually will make him sick. If he eats this food and becomes ill, he should not be punished if he tells his parents the truth. Instead, they should be kind to him—and psychologically reinforce the notion that he should not eat this food in the future.

However, to minimize this kind of testing, I tell each child that I will set specific periods when I will want him to eat the allergenic food to see if he is still allergic to it. Periodic testing of this kind will show whether or not during the interval of abstinence from it, he has developed clinically significant tolerance for it. In time, as a result of abstinence from an allergenic food, all but 2 % of individuals develop sufficient tolerance to the eliminated food to be able to eat it at least occasionally without developing allergic symptoms.

Complete or substantially complete compliance. When the child finally recognizes that the allergenic food makes him sick, he will not have much difficulty abstaining from it, whether or not he is under the direct observation of parents or parent surrogates.

Aberrant emotional reactions. However, in addition to the already enumerated normal emotional reactions to elimination

of allergenic foods from the child's diet, there are more serious reactions which are difficult to manage successfully. These include (a) denial of food-induced allergic illness, (b) denial of identification with an allergenic parent, (c) withdrawal from reality, (d) depression, (e) anxiety, (f) phobias, (g) hypochondriasis, (h) self-inflicted, food-induced allergic illness, and (i) asocial behavior, including delinquency.

Denial of food-induced allergic illness. Especially in adolescents, there are those who deny that allergenic foods give them an allergic illness, even though this fact is clear-cut to the child's parents and the doctor. Denial of food-induced allergic illness represents the child's method of denying his bodily inferiority; often, he makes an over-determined effort to eat the allergenic food and even when it makes him sick he will not complain. There are some elements of masochism in this situation, and of sadism also, since by eating the allergenic food, the child punishes not only himself, but also his parents.

In helping an allergic child, I explain his problems to him in this way: that good health is a relative matter. Some must wear glasses to improve visual functioning; others must take insulin to stay alive. Those allergic to specific foods also have special handicaps that cannot be concealed or ignored for long. Furthermore, constant ingestion of allergenic foods actually worsens the child's allergic state, making him more allergic to inhalants, contactants and foods. On the other hand, avoidance of allergenic foods tends to decrease the child's allergic sensitivity not only to these foods but often to his other allergens. If he eliminates the allergenic food, he improves his health.

The denial of reality in one sphere can soon spread to other areas of life, and such habits of emotional thinking can lead to serious difficulties in attaining desirable social, occupational and economic goals. With careful supportive psychotherapy, most of these children can be helped to accept the reality of food-induced allergic illness, and to make a successful emotional adaptation to these necessities of elimination therapy.

Denial of identification with an allergic parent through the denial of food allergy. Here, the child, usually an adolescent

male, believes that he has acquired his allergies by inheritance from his mother. The boy will be unconsciously afraid that in addition to his food allergies, he has inherited feminizing traits. In addition to denying his food allergies, he will display behavior designed to prove his virility and masculinity. He should be taught that one might inherit certain tendencies from an allergic parent of the opposite sex without at the same time being feminized. The rest of the therapy follows that already suggested for the denial of food-induced allergic illness.

Withdrawal from reality reactions. Some children who have eliminated allergenic foods from their diet and lose their allergic syndromes seem to develop tendencies to day-dream and to be withdrawn from their usual interests. They wish to be alone, day-dreaming about eating the forbidden food, and have no interest in having warm contacts with other children or adults. These children are helped if their lives are made pleasanter by trips to zoos, botanical gardens, wild-west shows, etc. Having parties for the child and getting him involved with activities of other children as much as possible, has a good therapeutic effect. Generally, this state is brief in those children who have displayed it.

Depression. Some children lacking the capacity to express through overt acts their resentment at being allergic to foods, may develop depressions—usually of mild degree. They may tend to regress and become much more dependent on adults, particularly parents, for emotional support. They may not wish to go to school or to compete with playmates of their own age. These children tend to be sad, have slowing of their psychomotor processes, and at times tend to have more accidents than other children. They are best treated by reassurance that they are loved, by periods of increased attention from parents, and by parties with other children. Some improve when they can be encouraged to talk about their anger and resentment at having food allergies. Psychotherapy, as always, has to be adapted to the needs of each child. Fortunately, depressions have been rather mild and transient in nature.

Anxiety, phobias and hypochondriasis. Some allergic chil-

dren develop anxiety that they might become allergic to other foods; they tend to be introspective and display an unhealthy over-concern about their own health. These children are difficult to treat. Through kindness and reassurance they can often be brought to have a more serene attitude toward life. One thing that helps such children is to have the privilege of calling the doctor directly, and telling him their symptoms over the telephone. The mere fact that the child has this privilege gives him considerable emotional reassurance, and after one or two trials, he will generally lose his tension and anxiety and be generally happier. With such children, it is often necessary when leaving town for me to let the child know directly that I have selected a good doctor to take my place. It will take more time and study to know if these children later in life will suffer from serious degrees of anxiety neurosis, phobias and hypochondriasis.

Self-inflicted illness. Some children deliberately eat the allergenic food to become sick and have secondary gains of illness. This is best treated by making it less worthwhile psychologically for the child to be sick and more worthwhile for him to be well.

Asocial behavior including delinquency. While staying on the elimination diet, some allergic children remain angry with their parents, doctor and the world around them, especially non-allergic friends and acquaintances. Such children may develop aggressive behavior toward others, even delinquency, as a method of expressing resentment and hostility. When they begin to talk about their attitudes toward themselves and their illness, they often say that it's a terrible thing for parents to give their children such ailments as food allergies; and that their anger is also directed against those lucky children who don't have their kind of allergic troubles. Once a child has been helped to gain insight into the nature of his emotional difficulties, it is often possible to channel his aggressiveness into more acceptable competitive channels, with the emphasis that it is better to reach constructive goals than destructive ones. The former leads to success in life, the latter, to failure.

In this short paper, I have been able to outline only the major emotional reactions of children to deprivation of allergenic foods from their diet. The doctor can best manage these secondary emotional reactions to elimination of allergenic foods from the patient's diet by initially alerting and educating the parents to the usual emotional reactions they might expect in an allergic child who is on an elimination diet, and how they can best manage such reactions when these occur. The informed parent is better able to cope with the child's adverse emotional reactions to deprivation of allergenic foods than he would be by trying to find his own solutions through trial and error. Parents are taught that a continuously firm but kindly attitude in dealing with the child's problems is most helpful. Parents must learn not to transfer their own anxieties to the child, and not to turn their own hostile impulses to the task of "disciplining" the child. The doctor should help parents recognize and correct their own adverse patterns of emotional reactions toward the child and his illness. As they succeed in improving their attitudes and emotional behavior, not only do they benefit, but the child becomes better adjusted to his food-induced allergic ailment.

Sometimes the entire family may have to forego the use of certain foods in order to help the child to stay on his elimination diet. This group deprivation often causes the child to feel less strongly that he has been singled out to be punished by being deprived of specific foods, and the family gains a better subjective understanding of some of the emotional stress of food deprivation for the child.

The most difficult type of adverse emotional reaction to manage therapeutically is that which occurs in the older child who realizes for the first time that he may have acquired his allergies from one or both allergic parents. A similar pattern of animosity toward a parent occurs in the hemophilic boy, and in the diabetic child of diabetic parents. The child wants to punish and humiliate his parents in the many ways at his disposal, and he does everything he can to cause them anguish. If he is helped to verbalize his hostile feelings, and if this is

accepted in a permissive manner, indicating that he can have such feelings and can express them verbally without punishment, he will find less need to act out his inner emotions in terms of hostile, aggressive and asocial behavior.

Some of these children are helped when they are made to realize that allergies can be acquired by many who do not have a clear-cut history of allergy in the family background. Furthermore, it helps a child to know that parents do not deliberately give their children allergies, and that a reasonably high percentage of children of allergic parents do not themselves have allergies. And that while allergies are a handicap to the individual, they may not be as great a handicap as many other emotional and physical problems that other children have. Children are often surprised to learn that their own attitudes of anger and resentment may make their allergies more severe. And that instead of concentrating on hating allergies or parents, they should concentrate on enjoying life as much as they can, and on preparing for their life's work. It often helps them to know that certain popular figures of the entertainment world are victims of asthma and other allergic diseases.

Although a child's emotional reactions to deprivation of allergenic foods are complex, in general, these are not difficult to recognize. Treatment, if it is to be successful, must have the full cooperation of both the child and his parents. Often, when properly managed, not only does the child improve in his total health, but both the parents and the child enjoy a better emotional relationship than existed prior to the child's therapy for his food allergies.

This document is a scanned copy of a printed document. No warranty is given about the accuracy of the copy. Users should refer to the original published version of the material.