Food-related suffering: listening to subjectivity and psychosocial dimensions in the pediatric hospital context[1]

Sofrimento alimentar: escuta da subjetividade e das dimensões psicossociais no contexto hospitalar pediátrico

Sufrimiento alimentario: escucha de la subjetividad y de las dimensiones psicosociales en el contexto hospitalario pediátrico

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ABSTRACT

Eating disorders and manifestations of eating-related suffering are traditionally understood from the perspective of diagnostic classifications focused on the behavioral and physiological aspects of the symptom. In the pediatric hospital context, it is observed that the persistence of food refusal, somatic complaints, and low adherence to treatment can go beyond what is explained solely by biomedical logic. This article aims to discuss the contributions of psychoanalysis and hospital psychology to the understanding of these manifestations, highlighting the attention to subjectivity and the psychosocial dimensions involved in the symptom. It is a theoretical-conceptual discussion, based on literature, linked to contributions from psychoanalysis and hospital psychology regarding eating manifestations in the pediatric hospital context. Food refusal is seen as a possible expression of psychological and psychosocial suffering, considering its connection to the body, how others see the person, experiences of social exclusion, and the role of the hospital environment as a potential space for listening and acknowledging subjectivity. It is concluded that combining hospital psychology, psychoanalysis, and the multidisciplinary team expands the possibilities for understanding and clinical management, taking into account not just the person's physical stabilization, but also their individuality, relationships, and living conditions.

Keywords: Eating Disorders. Food Refusal. Hospital Psychology. Psychoanalysis. Psychosocial Suffering.

RESUMO

Os transtornos alimentares e as manifestações de sofrimento alimentar são tradicionalmente compreendidos pela perspectiva de classificações diagnósticas centradas nos aspectos comportamentais e fisiológicos do sintoma. No contexto hospitalar pediátrico, observa-se que a persistência da recusa alimentar, das queixas

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somáticas e da baixa adesão ao tratamento pode ultrapassar aquilo que é explicado exclusivamente pela lógica biomédica. Posto isso, este artigo tem como objetivo discutir as contribuições da psicanálise e da psicologia hospitalar para a compreensão dessas manifestações, destacando a escuta da subjetividade e das dimensões psicossociais implicadas no sintoma. Trata-se de uma discussão teórico-conceitual, de caráter bibliográfico, articulada a contribuições da psicanálise e da psicologia hospitalar sobre manifestações alimentares no contexto hospitalar pediátrico. A recusa alimentar é analisada como possível expressão de sofrimento psíquico e psicossocial, considerando sua relação com o corpo, o olhar do Outro, as experiências de exclusão social e a função do ambiente hospitalar como possível espaço de escuta e reconhecimento da subjetividade. Conclui-se que a articulação entre psicologia hospitalar, psicanálise e equipe multiprofissional amplia as possibilidades de compreensão e manejo clínico, ao considerar não apenas a estabilização orgânica do sujeito, mas também sua singularidade, seus vínculos e suas condições de vida.

Palavras-chave: Transtornos Alimentares. Recusa Alimentar. Psicologia Hospitalar. Psicanálise. Sofrimento Psicossocial.

RESUMEN

Los trastornos alimentarios y las manifestaciones de sufrimiento alimentario se comprenden tradicionalmente desde la perspectiva de clasificaciones diagnósticas centradas en los aspectos conductuales y fisiológicos del síntoma. En el contexto hospitalario pediátrico, se observa que la persistencia de rechazo alimentario, de las quejas somáticas y de la baja adherencia al tratamiento puede superar lo que se explica exclusivamente por la lógica biomédica. Este artículo tiene como objetivo discutir las contribuciones del psicoanálisis y de la psicología hospitalaria para la comprensión de estas manifestaciones, destacando la atención a la subjetividad y a las dimensiones psicosociales implicadas en el síntoma. Se trata de una discusión teórico-conceptual, de carácter bibliográfico, articulada a contribuciones del psicoanálisis y de la psicología hospitalaria sobre manifestaciones alimentarias en el contexto hospitalario pediátrico. Rechazo alimentario se analiza como una posible expresión de sufrimiento psíquico y psicosocial, considerando su relación con el cuerpo, la mirada del Otro, las experiencias de exclusión social y la función del entorno hospitalario como posible espacio de escucha y reconocimiento de la subjetividad. Se concluye que la articulación entre psicología hospitalaria, psicoanálisis y el equipo multiprofesional amplía las posibilidades de comprensión y manejo clínico, al considerar no solo la estabilización orgánica del sujeto, sino también su singularidad, sus vínculos y sus condiciones de vida.

Palabras clave: Trastornos Alimentarios. Rechazo Alimentario. Psicología Hospitalaria. Psicoanálisis. Sufrimiento Psicosocial. Sufrimiento Psicosocial.

INTRODUCTION

In the hospital setting, specifically in pediatric care, manifestations of food-related suffering frequently mobilize multiprofessional teams due to the complexity of symptoms that simultaneously involve organic, subjective, family, and social dimensions. Although medical conduct legitimately and necessarily prioritizes the clinical and nutritional stabilization of the patient, it is observed that, in many situations, the persistence of food refusal, nausea, vomiting, somatic complaints, and low adherence to proposed interventions may exceed what is explained exclusively by biomedical logic. In these cases, the food-related symptom calls for a broader reading, one capable of considering not only the functioning of the organism, but also the listening to subjectivity and psychosocial issues that may be involved in the subject's relationship with the body and with food.

The diagnostic understanding of eating disorders and food-related manifestations associated with psychic suffering plays an important role in the health field, especially because it facilitates communication among professionals and guides clinical conduct. However, when the reading of the symptom is restricted to its behavioral or physiological dimension, there is a risk of reducing the subject to the condition presented, disregarding the complexity of their history, bonds, affective experiences, and living conditions. In the pediatric hospital context, this issue becomes even more sensitive, since children and adolescents do not always have sufficient symbolic resources to name what they experience, and may communicate their suffering through the body, refusal, pain, or difficulty adhering to treatment.

In this context, hospital psychology occupies a fundamental place by enabling a differentiated form of listening, directed toward the subject's singularity and the meanings involved in the way they experience the process of illness, hospitalization, and care. Psychological practice in the hospital is not limited to promoting adherence to treatment, although this is also an important dimension of care. Its contribution lies, above all, in the possibility of shifting the reading of the symptom from an exclusively organic perspective to an understanding that includes subjectivity, family bonds, the relationship with the team, and the social crossings that may participate in the production and maintenance of suffering.

From the perspective of psychoanalysis, anorexia, bulimia, food refusal, and other manifestations of food-related suffering are not reduced to disorders of eating behavior or physiological alterations. Rather, they may and need to be understood as expressions of psychic suffering and as particular forms of relationship with the body, desire, lack, and the Other. In this sense, contributions from the founder of psychoanalysis, Freud, and from Jacques Lacan in his return to Freud's work, make it possible to think of the food-related symptom not merely as something to be eliminated, but as a formation endowed with meaning, which may indicate impasses in the subject's relationship with demand, care, the body, and the experiences that affect them.

Psychoanalytic reading also makes it possible to understand that food does not occupy only a nutritional function. From the earliest moments of life, feeding is articulated with care, the presence of the Other, and experiences of satisfaction, frustration, demand, and bond. Therefore, when food becomes an impasse in the subject's life, whether as

refusal, excess, or suffering, it may indicate something that exceeds the plane of physiological need. Food-related suffering, in this sense, may be thought of as a manifestation that calls for listening to that which does not find elaboration through words, but presents itself in the body and in the relationship with the other.

However, understanding the food-related symptom in the pediatric hospital context also requires attention to the psychosocial dimension. Experiences of exclusion, bullying, social vulnerability, family conflicts, difficulties connected to the territory of living, ruptures in routine, and suffering in the social bond may produce important subjective effects, affecting body image, the relationship with food, and the way children or adolescents communicate their suffering. Thus, the symptom is not organized only in the biological body, but also in the relationship between the subject, their bonds, and the concrete conditions of their existence.

In addition, the hospital environment may appear as an ambiguous function. At the same time that it is marked by illness, pain, disruption of routine, and clinical urgency, it may also become a space for listening, welcoming, and recognition. The presence of the multiprofessional team, when articulated in a way that is sensitive to the subjective and social dimensions of illness, may favor the construction of care strategies that are not limited to the remission of physical symptoms, but also consider continuity of follow-up, family guidance, and articulation with other points in the care network after hospital discharge.

Given this, this article aims to discuss the contributions of hospital psychology and psychoanalysis to the understanding of food-related manifestations in the pediatric hospital context, highlighting the importance of listening to subjectivity and the psychosocial dimensions involved in the symptom. To this end, a theoretical-conceptual discussion of a bibliographic nature is developed, articulated with contributions from psychoanalysis and hospital psychology regarding food-related symptoms, food refusal, and the impasses of health care. Food refusal is taken as a starting point to think about subjective and psychosocial dimensions that exceed organic stabilization and call for listening directed toward the subject's singularity, their history, their bonds, and the living conditions that traverse suffering in the pediatric hospital context.

THE SYMPTOM: BETWEEN MEDICINE AND PSYCHOANALYSIS

Contemporary psychiatry, through manuals such as the DSM-5-TR (2023), defines feeding and eating disorders as persistent disturbances in eating behavior that result in altered consumption or absorption of food and significantly impair physical health or psychosocial functioning. This approach, although essential for diagnosis and clinical management, is based on a descriptive and statistical logic centered on the observation of phenomena.

Psychoanalysis, in view of this, points to a parallel path in the understanding and management of eating disorders. This theory works with the subject's subjectivity, distancing itself from the descriptive, statistical, and phenomenological logic of manuals. Even with this difference, according to Vianna (2016), entering this path does not presuppose adopting a merely biological or generalized view of food-related suffering, but rather requires dialogue with different professionals in order to establish interlocution and, in this way, construct a multidisciplinary view of the theme.

Following this logic, according to Malzyner (2016), work with patients who present eating-related issues requires a constant dialogue that demands finding a common language with the Other professionals who participate in a multidisciplinary team. This makes it possible to rethink daily practice and review the form of work. For effective communication, it is necessary to know and to be able to dialogue with the way psychopathological phenomena are understood.

Freud (1926/2014) elaborates that the symptom is the true substitute and derivative of a repressed impulse that continuously renews its demands for satisfaction, causing the ego to produce a signal of unpleasure and to place itself in a defensive position. Regarding this, Malzyner (2016) explains that cure in psychoanalysis is a quite complex concept and distances itself from medicine insofar as it does not seek the elimination of the symptom. From the medical perspective, a person suffering from eating-related issues must quickly abandon their symptomatology, and it is in this way that physicians measure the degree of success of treatment.

Keeping in mind what Freud mentioned about symptom formation and bringing in Malzyner's (2016) ideas, in psychoanalysis the symptom is taken as something that expresses a movement of the ego seeking to free itself from unbearable suffering. Thus, according to the psychoanalyst, differently from the medical perspective, the analyst makes use of the symptom as an indirect pathway in order to work through and dissipate

unconscious pain. Therefore, it may be stated that cure is not the goal of an analysis, but a consequence.

Also according to the same author, it is necessary for the analyst to be capable of dialoguing with the multidisciplinary team, which, at various moments, has as the central axis of treatment the elimination of the symptom. However, the practitioner of psychoanalysis cannot simply follow the team in this pursuit. If they do so, they run the risk of hindering the treatment and attempting to adapt the subject to the desire of the Other, repeating a dynamic that is quite common in the families of these patients. Moreover, McDougall (1997 *apud* Malzyner, 2016) contributes by bringing the idea that the analyst's sole objective is to understand the patient's psychic experience and communicate it, with the hope that the subject assumes full responsibility for their choices and acts.

FOOD REFUSAL, PSYCHOSOCIAL SUFFERING, AND HOSPITAL LISTENING

Before proceeding, it is important to emphasize that this article does not aim to discuss anorexia and bulimia in their diagnostic entirety, nor to reduce hospital food refusal to these conditions. Psychoanalytic formulations on anorexia and bulimia are revisited because they allow the food-related symptom to be considered beyond its organic and behavioral dimensions, offering theoretical elements for understanding food refusal as a manifestation that may involve the body, desire, the Other, and psychosocial suffering.

From the Lacanian rereading, anorexia may be understood not as a simple "not eating," but as "eating nothing." Lacan (1956-1957/1994) approaches this as follows: it is not a *nicht essen* ("not eating"), but rather a *nichts essen* ("eating nothing"). This Lacanian formulation indicates that the symptom is not reduced to food refusal, but has a symbolic dimension related to the subject's position before the Other. This results in a symbolic plane of eating nothing, which may suggest that something beyond the physical act of eating is being displayed. The "nothing," in this context, assumes a psychic value, functioning as an attempt at a subjective response to the demands of the Other. In this way, anorexia exceeds the merely physiological dimension and appears articulated with unconscious conflicts, the articulation of desire, and the subject's particular forms of relationship with the body and the social bond.

In this context, anorexia may be understood as an attempt to establish a lack in the Other, especially in the relationship with the maternal figure. When the demand of the Other is experienced as invasive or suffocating, the subject resorts to "nothing" as a strategy of separation. Thus, for Pena (2014), the symptom does not express only deprivation, but a subjective operation that seeks to delimit a space for desire. In this sense, the body comes to occupy a place of manifestation of this psychic suffering. What does not find the possibility of symbolization or elaboration through words may emerge through the food-related symptom, showing that the body is not only a biological organism, but also a space of the subject's subjective and affective experiences.

This dynamic may be articulated with the operations of alienation and separation. Lacan (1964/1998) elaborates that, in alienation, the subject is constituted from the desire of the Other, initially occupying the position of object. In separation, in turn, the psychoanalyst explains that there is the possibility of emerging as a desiring subject through the introduction of lack. In this sense, difficulty in carrying out this separation may lead the subject to remain excessively captured by the demands of the Other, finding in the food-related symptom an attempt at subjective delimitation. Thus, food refusal may appear as a paradoxical form of affirmation of desire, even at the expense of the body itself.

Furthermore, food refusal may be related to the oral drive, since, according to Freud (1915/2013), the drive does not have a fixed object of satisfaction, being marked by a constant search. From this perspective, "eating nothing" may be understood as a way of circling the lost object, showing that no food is capable of fully satisfying the drive. In this sense, food exceeds its biological function and comes to occupy a symbolic place in the subject's psychic economy. Food ceases to represent only bodily nutrition and becomes articulated with affective experiences, early relations of care, and forms of inscription of desire. Thus, food refusal may appear as an expression of subjective conflicts related to dependence, separation, and the relationship with the Other.

In the case of bulimia, a distinct movement is observed, marked by binge eating followed by purgative behaviors. This cycle may be related to the Freudian concept of repetition compulsion. Freud (1920/2020) explains that this compulsion that repeats causes unpleasure for the subject, but because it is also at the service of the pleasure principle, there is satisfaction. This repetition is a return of the same, of experiences; that is, the subject finds themself trapped in a circuit that simultaneously produces pleasure and

unpleasure. Differently from anorexia, in which "nothing" appears as a central operator, in bulimia there is often a movement marked by excess, impulsivity, and difficulty symbolizing psychic tensions. The binge-purge cycle may be understood as an attempt to fill a subjective lack that, however, is never fully satisfied, repeatedly producing feelings of guilt, anguish, and emptiness.

The excessive ingestion of food may be understood as an attempt to appease psychic tensions, while the act of vomiting appears as a form of rejection of the object and, at the same time, of separation in relation to the Other. This movement may also be related to the fort-da game described by Freud (1920/2020) in Beyond the Pleasure Principle, in which the alternation between presence and absence symbolizes an attempt to elaborate loss.

Fagundes Netto *et al.* (2013) elaborate that, both in anorexia and in bulimia, the symptom may be understood as a strategy for establishing desire by producing a lack in the Other. Thus, these disorders should not be reduced to eating disturbances, but understood as complex expressions of the subject's relationship with desire, the body, and the Other. In addition, it is worth emphasizing that food-related symptoms are also traversed by the individual's social and cultural experiences. Issues related to exclusion, symbolic violence, body ideals, and experiences of suffering in the social bond may participate in the constitution and maintenance of these conditions, especially in contemporaneity.

Psychoanalytic contributions to the understanding of food-related symptoms can be observed since the earliest Freudian writings, in which articulations between food, psychic suffering, childhood experiences, and family relations already appeared. From this perspective, the food-related symptom may be understood as a form of subjective language. When certain experiences do not find the possibility of symbolic elaboration, the body and food come to occupy a privileged place for the expression of suffering.

With this in mind, the case of Emmy von N. may be cited. Entering the description of the case, Freud (1893-1895/2016) treated this patient through visits to a sanatorium, describing her as hysterical. In one of the visits, Freud reports that the patient complained of severe stomach pains. In view of this, he asked her to try to identify the origin of these pains, asking whether she remembered any occasion on which she had forced herself to eat after experiencing intense emotions. From this, Freud was later able to determine that, after the death of her husband, the patient had completely lost her appetite and began eating only

out of obligation. According to the author, the stomach pains began during this same period.

Freud (1893-1895/2016) continues by reporting that, after a few weeks, Emmy remained under his observation and appeared to be in good health. However, at the end of her stay, a situation occurred that, according to him, shed light on the patient's character and on the way in which her states had been produced. During a visit at lunchtime, Freud was surprised to find a dried-out dessert that had remained there for days, which led him to examine the Other plates of food she had left. When he questioned her about why she ate so little, the patient replied that she was not accustomed to eating more than that and that, if she did so, it would harm her, since this characteristic had the same origin as her father, who also ate very little. Later, Freud advised her to drink more water and increase the amount of food she consumed. Faced with this suggestion, the patient, agitated, responded: "I will do this because you demand it, but I warn you that it will end badly, for it goes against my nature and my father was also like this" (Freud, 1893-1895/2016, p. 67).

The next day, the patient told Freud that she had severe stomach pains, attributing them to the increased food intake and water consumption. Addressing the physician, she stated: "[...] I have ruined my stomach, and I must starve again for five to eight days until I can tolerate anything" (Freud, 1893-1895/2016, p. 67).

Still in the case description, Freud reports that, during another visit, he hypnotized the patient, a method that would later be abandoned, and again asked her why she could no longer eat more. Immediately, her response was (Freud, 1893-1895/2016, p. 68):

> [...] when I was a child, it often happened at the table that I, out of bad manners, did not want to eat my meat. My mother was always very strict on those occasions and, under threat of severe punishment, forced me to eat it two hours later, on the same plate on which I had left it. The meat was completely cold and the fat so stiff (disgust), and I still see the fork before me. When I sit at the table now, I always see before me the plate with cold meat and the fat.

The patient reports that she had meals with her siblings, one of whom had tuberculosis and another who, also ill, spat on the plate during meals. Months later, Freud received a letter from Emmy informing him that she was eating well and gaining weight. In view of this, Freud (1893-1895/2016), when discussing the case, states that the patient's anorexia offered an example of abulia, in this case related to food and water. For the author, the fact that she ate little, or stopped eating under the justification that the foods did

not please her, was related to the association between the act of eating and repugnant childhood memories whose affective charge had not diminished. The reduction of disgust linked to meals did not occur because the patient was repeatedly forced to repress it, instead of expressing it or elaborating it through a reaction. In childhood, out of fear of maternal punishment, she was forced to eat with disgust; later, out of consideration for her siblings, she prevented herself from expressing the unpleasant feelings she experienced during shared meals.

According to Gomes *et al.* (2020), when analyzing this case, Emmy associated the act of eating with childhood memories marked by repulsion. This association was justified by experiences in which the mother, described as severe, forced her to eat all the food, even when cold and hours after it had been prepared, as well as by the coexistence with ill siblings during meals. For the authors, although Freudian psychoanalysis did not emphatically dedicate itself to the study of anorexia as a disorder, there are indications that the construction of psychoanalysis did not disregard the importance of phenomena of deprivation and food restriction, as observed in Emmy's case.

Still within the Freudian contributions to the understanding of anorexia and food refusal, it becomes important to mention the concept of drive and how it may be articulated with this theme, without disregarding the later contributions of Jacques Lacan. Therefore, Freud (1915/2013), in the text Drives and Their Vicissitudes, conceptualizes the drive as something situated between the psychic and the somatic, highlighting that it does not act as a momentary force, but as a constant force. For the creator of psychoanalysis, the aim of the drive is always satisfaction, while its object is that through which this satisfaction may be achieved.

However, this object is not fixed, nor necessarily material; it may vary and may even correspond to a part of the human body itself. Precisely because of this variability, there is no specific object capable of guaranteeing full and definitive satisfaction, which causes the circuit of the drive to remain in constant movement.

In *Beyond the Pleasure Principle*, Freud (1920/2020) advances his elaboration of the drive. He writes that the drive is like a pressure inherent to the living organism, directed toward the restoration of an earlier state that was abandoned under the influence of external forces. In this sense, the drive also comes to be understood as an expression of a conservative tendency in organic life.

When developing this formulation, Freud continues to sustain that life contains a tendency to return to an initial state, prior to the disturbances imposed by existence itself. It is along this path that he formulates the notion of the death drive, affirming that the aim of all life would ultimately be death. This elaboration allows the thought that drive satisfaction will not always be oriented toward the preservation of the organism, and may also, therefore, be articulated with forms of repetition of jouissance that place the subject before important impasses.

Lacan (1964/1998), in *Seminar XI*, states that the drive obtains satisfaction only by circling the object a, which is the representative of a structurally lacking object. Thus, its aim is not confused with the direct apprehension of an object, but with the return to the drive's own circuit. For the French psychoanalyst, there is always something of the drive to be satisfied, which allows one to understand its constant force. From this reflection, Pena (2014) emphasizes that the symptom, as in the case of anorexia and food refusal, precisely evidences the radicality of the lack of a specific and natural object for the subject. The anorexic person, through "eating nothing" in the form of refusal, shows that it is not food itself that satisfies the oral drive, but the circling around the void left by the object that has always already been lost. In this sense, Lacan (1964/1998) states that no food will ever fully satisfy the oral drive except by circling this eternally lacking object.

Miller (1998), when commenting on the Lacanian formulation of the drive, contributes to this discussion by stating that eating is not merely a satisfaction of the oral drive. Food may appear as the object or aim of the drive, but the objective of the drive is jouissance, which may be achieved even without the ingestion of food. Taking anorexia as an example, the author indicates that the anorexic subject, by eating nothing, may extract from this a form of oral jouissance elevated to a potentially lethal point, approaching the dimension of the death drive. This reading makes it possible to articulate food refusal not only with lack of appetite or with the refusal of food itself, but with a drive dynamic in which the body, emptiness, and jouissance are intertwined. Thus, anorexia may be understood as a symptom that calls for a listening beyond the merely organic dimension, questioning the subjective function that food refusal assumes for each subject.

In contemporaneity, when this discussion is shifted to the pediatric hospital context, it is observed that certain food-related manifestations may exceed what is explained exclusively by the organic dimension. In situations of hospitalization, the persistence of

somatic complaints, nausea, frequent episodes of vomiting, low adherence to proposed interventions, and persistent food refusal may call upon the care team to consider not only the patient's clinical stabilization, but also the subjective and psychosocial meanings involved in the symptom. In these cases, even when medical intervention does not reveal alterations proportional to the intensity of the complaints, suffering may continue to express itself through the body and through the relationship with food.

In this scenario, the psychology professional may be called upon as a possibility for broadening the understanding of the clinical picture, offering a form of listening that will not be restricted solely to food or medication adherence. The construction of the bond, the use of playful resources in pediatric care, and listening to the family members present may favor the emergence of elements that initially do not appear in verbal language, but are presented through the body, refusal, and somatic complaints. In this way, psychological intervention is not oriented only toward the attempt to eliminate the symptom, but toward the possibility of understanding the place it occupies in the subject's psychic economy.

From this perspective, food refusal may be thought of as a manifestation that condenses not only psychic suffering, but also the effects of the psychosocial conditions in which the ill subject is inserted. Experiences of exclusion, bullying, social vulnerability, family conflicts, ruptures in routine, and difficulties in the bond with the Other may also affect body image, self-esteem, and the relationship with food. Thus, the food-related symptom is not organized in the biological body alone, but also in the relationship between the subject, their bonds, and the concrete conditions of their existence.

This reading makes it possible to bring Freud's formulations on the case of Emmy von N. closer to situations that may emerge in the contemporary pediatric hospital. In the Freudian account, eating difficulties appear associated with childhood memories marked by repulsion, imposition, and suffering in family relations. Similarly, in current hospital contexts, persistent food-related manifestations may indicate that the act of eating is traversed by affective, family, and social experiences that exceed the physiological need for nutrition. The comparison does not seek to equate distinct clinical contexts, but to show that, since Freud, eating can be understood as a field traversed by subjectivity.

Having said this, experiences of ridicule, rejection, or social exclusion may allow one to think of the body as a place upon which the gaze of the Other is inscribed. In childhood and adolescence, such experiences may produce important effects on the

constitution of body image and on the subject's relationship with their own body. Thus, the food-related complaint should not be analyzed only as a behavioral alteration or resistance to treatment, but as a possible response to experiences in which the subject feels exposed, devalued, or without sufficient symbolic resources to elaborate what affects them.

Although the hospital environment is frequently associated with pain, illness, and disruption of routine, it may also occupy an ambiguous function. At the same time that it marks the presence of illness, it may offer a temporary suspension of external experiences felt as threatening, in addition to making possible an encounter with a team capable of listening to suffering beyond the organic complaint. In this sense, hospitalization should not be understood only as a consequence of a clinical condition, but also as a scene in which the subject may find, through the mediation of the team, possibilities for listening, recognition, and elaboration.

The psychosocial dimension of food-related manifestations also indicates that hospital discharge should not be thought of only from the perspective of organic improvement. When the symptom is articulated with social conditions of suffering, it becomes fundamental to construct continuity of care involving outpatient psychological follow-up, family guidance, and, when possible, articulation with the health network, social assistance, and the school environment. In this way, the work of the team is not limited to the remission of physical symptoms, but seeks to favor conditions of care that consider the subject's bonds, history, and territory.

In this process, listening to the family assumes fundamental importance, not with the aim of locating blame, but of understanding how the symptom is perceived, interpreted, and managed in the family environment. In situations of food refusal, the anguish of caregivers may lead to insistent attempts to control eating, which, although understandable, may intensify the tension around eating. The psychologist's intervention, therefore, may favor mediation among subject, family, and team, enabling other ways of reading the symptom and reducing the tendency to understand it only as opposition, resistance, or disobedience.

From this, the articulation among psychology, medical team, nutrition, social work, and other areas involved in care becomes fundamental. Food-related manifestations associated with psychic suffering in childhood demand a multidisciplinary approach capable of integrating biological, subjective, family, and social aspects. In this context,

psychoanalysis contributes by sustaining listening to singularity, considering the symptom as a formation endowed with meaning and not merely as a behavior to be eliminated.

One of the central concepts for thinking about this listening is transference. In *On the dynamics of transference*, Freud (1912/2017) writes that each subject has a particular way of conducting their love life, constituting a cliché that tends to repeat itself throughout life, both in external conditions and in the choice of love objects. In this movement of repetition, the figure of the analyst may be included and articulated with parental images or other significant figures. Freud (1912/2017) warns, however, that transference is not restricted to the paternal model, and may also be organized from the maternal imago, the fraternal imago, or other important figures for the subject. Moreover, in transference, not only conscious elements are present, but also retained or unconscious contents.

For Freud (1925/2011), an analysis without transference is impossible. The author emphasizes that transference is not created by analysis, nor does it occur exclusively within it; analysis merely unveils and isolates it. Thus, transference may be understood as a general human phenomenon, present in relationships and decisive for the success of different forms of influence in the field of care. Freud (1925/2011) also develops that the analyst makes the subject conscious of the transference, showing that transference conduct updates emotional bonds originating in childhood. Thus, transference passes from one of the strongest weapons of resistance to the best instrument of analysis, and its management is one of the most difficult and important parts of psychoanalytic technique.

Alonso (2016, p. 43) contributes to this discussion by addressing transference in the treatment of eating-related impasses, especially when this treatment occurs in articulation with a multidisciplinary team, even before reaching the psychology professional:

> [...] The team will be responsible for informing the indispensable need for the process and clarifying some doubts of both the patient and their family members, thereby providing the necessary support for the search for therapy. Often it is only through this firm sustaining of the extreme necessity of the psychotherapeutic process, encounter after encounter, with the rhythm of comings and goings, that the analytic relationship can be established, strengthened, and reach, in transference, the full potential of the work. The result is the construction of a symbolic therapeutic setting capable of offering such a space of intimacy so that the patient - within their authorial path of constructing their own narrative - may come.

Still with Alonso's (2016) contributions, the constant and active presence of the team symbolically promotes an experience of contour, like a border that indicates limit,

risk, and direction to follow. The author illustrates this function through a patient's statement: "it will not be easy, but, on the other hand, I see you as my reverse parachute, who, when I cannot do it alone, will not let me crash" (Alonso, 2016, p. 44). For the psychoanalyst, this statement shows that the team may function as the one that activates warning signs for patients and family members, especially when they, immersed in certain forms of bond, are unable to recognize aspects of exclusion, control, and fusionality present in relationships.

Alonso (2016) continues by stating that the analytic relationship has as its material for work resistances, acting outs, and other modes of psychic functioning. However, when family dynamics also participate in the treatment, the analytic relationship becomes traversed by contact with the psychiatrist, nutritionist, and other professionals, through whom the analytic relationship will also be worked on. In this sense, the position of the analyst must safeguard the subject's relationship with their psychic body, which, still without contours and sufficient limits to sustain it, may reveal a kind of psychic nutritional deficiency, whether through the experience of emptiness or through that which overflows.

In this process, invasions and overflowings may also arise on the part of family members, which requires careful attention in the management of the case. For Alonso (2016), the analyst's position should be neither excessive nor lacking, but should be situated in a just measure. This implies the need for an active position, one that tolerates not knowing and is careful not to run over the patients' own construction of knowledge, especially when dealing with subjects who present a symbolic emptiness and, often, scarce free association.

Although separated by distinct historical and institutional contexts, the case of Emmy von N. and the food-related manifestations observed in the contemporary hospital context make it possible to sustain the same direction of reading: food-related symptoms should not be understood exclusively from the organic dimension. In the Freudian account, eating difficulties were related to childhood memories charged with unpleasure, imposition, and repulsion. In the contemporary pediatric hospital, persistent eating complaints may be articulated with experiences of social exclusion, psychosocial suffering, family conflicts, and difficulties lived in the bond with the Other.

Although the clinical manifestations are distinct, both the Freudian reading and contemporary hospital listening show that eating may function as a field of subjective

expression. The body, in this sense, does not appear only as an organism to be stabilized, but as a place traversed by affective, family, and social marks. Thus, clinical listening makes it possible to shift the focus from immediate symptomatic remission to the understanding of the function that the symptom may assume for each subject.

In this way, hospital psychology, articulated with psychoanalysis and the multiprofessional team, contributes to thinking food refusal and other food-related manifestations beyond the logic of adherence or resistance. It is a matter of sustaining a form of listening that recognizes the complexity of human suffering, considering the subject's singularity, history, bonds, and living conditions. This direction does not oppose medical care, but broadens its possibilities by including the subjective and psychosocial dimensions in clinical management.

FINAL CONSIDERATIONS

Eating disorders and food-related manifestations associated with psychic suffering constitute complex phenomena traversed by organic, subjective, family, and social dimensions. In this sense, their understanding requires an approach that goes beyond an exclusively biomedical logic, without disregarding the importance of clinical and nutritional stabilization. In the pediatric hospital context, which is the focus of this work, psychology, articulated with psychoanalysis, contributes by sustaining a form of listening directed toward the subject's singularity and the meanings involved in the symptom.

The discussion developed here makes it possible to understand that the persistence of food refusal, somatic complaints, and low adherence to proposed interventions may, in certain hospital situations, express forms of suffering that are not explained only by the physiological dimension. Elements such as social exclusion, experiences of bullying, family vulnerabilities, and difficulties in the bond with the Other may affect the subject's relationship with the body and with food, indicating that the food-related symptom may also be articulated with psychosocial experiences marked by helplessness, exposure, and suffering before the gaze of the Other.

In this way, the practice of hospital psychology proves important not only for favoring adherence to treatment, but mainly for shifting the reading of the symptom from an exclusively organic perspective to a broader understanding that includes the subject's history, bonds, living conditions, and subjective position in the face of illness. The

construction of transference, listening to the family, and, in the case of pediatric care, the use of playful resources as mediators of speech may favor the emergence of contents initially communicated through the body, opening space for subjective elaboration.

Finally, the importance of multidisciplinary work is emphasized in the construction of care strategies that integrate clinical stabilization, subjective listening, family welcoming, psychosocial attention, and continuity of follow-up after hospital discharge. Thus, it is understood that listening to subjectivity does not oppose medical care, but broadens the possibilities of understanding and intervention in the face of human suffering in the pediatric hospital context.

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