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Twelve Years Later: From "Fraiberg in Paris" to Attachment Theory applied to community health care centers for family and toddlers

By
Nicole Guédeney, M.D., Ph.D. and Antoine Guédeney, M.D.

We wish to present here the main changes attachment research has brought into our clinical practice with parents of infants and toddlers. Our context of work is community mental health care centers in Paris: the Infancy Units provide free services to families with children under 5, in their allocated local districts. Infant psychiatrists are in charge of the assessment and the treatment planning, as well as the direct clinical work with parents and infants. Our general approach comes from the field of developmental psychopathology.

Contents

1. THINKING ABOUT THE SIGNIFICANCE OF THE REFERRED PARENTS' HELP-SEEKING BEHAVIORS

Bowlby (1988) emphasized *the universal meaning of the process of help-seeking* and the well known equivalence between proximity-seeking and care eliciting. Seeking help shows the parent's attachment Internal Working Models (IWMs) which govern his or her expectations in the context. In child mental health, parents are entering a care seeking process on behalf of their child (Fraiberg, 1980), although most of them would never have applied for it or even entertained the idea for themselves. They are seeking help for their child: whatever is said or whatever shows up should be considered also as an indicator for their care-giving IWMs. Seeking help will activate for each parent a complex picture of procedural, semantic, and episodic memories.

In child mental health as opposed to adult mental health, the working alliance has to be achieved with the parents as well as with the child. The first session is very often decisive in terms of the continuation of the evaluation (and eventually of the treatment). Parents need to feel from the very beginning that they will want to come again or at least that they will feel they can do so, without running any risk or feeling threatened. We can help the parent only if he or she has sufficient trust in the fact that this is possible, that he or she can trust us, that it is worth the effort, and that the cost to him or her will not be too high.

The insecurely attached parent therefore entails two risks while meeting the mental health clinician for the first time: the difficulty to make a relational "engagement", and to explore painful affects, with a serious risk of rupture or breaking-off (Bowlby, 1977). In these cases, a conflict between the parent's attachment and care-giving systems may arise and will be expressed through ambivalent help seeking behaviors towards the clinician.

Systematic exploration of parents' help-seeking behaviors, and attitudes towards help is therefore a source of valuable information about the conflict between their willingness to help their child and their own fear of receiving help: *Have they already had experience, direct or indirect, of obtaining help from professionals like us?* ("The Bureaucratic Transference" as Seligman & Pawl wrote, 1984) *Who was involved? How did it go? What did they think? Have they had experience with other professionals?* We then explore whether in general, help-seeking is viewed by them as a legitimate or illegitimate behavior (Bowlby, 1988). *What do their family, social and individual cultures have to say? How do they construct their own personal general theory? Have there been changes linked to life events, or encounters, in the private sphere or among professionals? What specific memories do they have of asking for help?* Any negative experience reported by the parents about help seeking

with professionals as generalized is considered as a "warning" signal: the parent is probably not secure.. The explicit utterances of the parent about the process of help seeking by itself are particularly relevant (Braconnier et al, 2006): *"The parent runs down the process", "The parent has come but only because he/she was asked to do it", "He/she expresses fear of dependency if he/she begins to work with us", "For the parent, asking for help means vulnerability or weakness", "he / she expresses mistrust about the professional's willingness or ability to help and to protect or comfort"*.

2. PARENTS MEETING A PROFESSIONAL IN CHILD MENTAL HEALTH FOR THE FIRST TIME

This context, –meeting a professional within the context of care eliciting, -is a paradigm of an attachment-activating situation: a distressed or vulnerable subject, who is unable to cope on his or her own, encounters a professional, i.e. a person "who is stronger, wiser and willing to help" (Bowlby, 1988). This leads us to the unique meaning of this first meeting for the parents' own attachment system (Crowell, 2003). Once again, we can help the parent only if he or she has sufficient trust in the fact that this is possible, that he or she can trust us, that it is worth the effort, and that the cost to him or her will not be too high.

The reactions of parents to this context provide valuable indicators on any insecurity in the parents from the outset, without more detailed information being required on their history of attachment. This new type of semiology includes the following: The concrete manifestations of the parental perception of help seeking often start to appear before the first encounter, such as during the phone call for scheduling the appointment, technical difficulties to get to the clinic, criticisms about the quality of reception by staff (Brisch, 2002) and so on. We pay special attention to the parent's reactions at times of "reunions and separations", such as at the beginning of the meeting and at its impending termination. Also, are there "unexpected" attitudes, such as the parent giving a boring wealth of factual details about the child, or the parents threatening to leave the child alone in the waiting room or in the consultation room if he/she does not obey them. Are there clues as to what the parent views as the most important thing, such as fulfilling their own expectations as he/she imagines them, or rather meeting their child's needs? The observed contrast between the parent's apparent willingness to collaborate with and to please the professional while not comforting the child's distress is often an indicator of a "Parentified" child (Liotti, 2004). Generally speaking, our attention is drawn as much by what we see as by what we do not, but should, see; as much by what we are told as by the way it is told (Crowell, 2003).

3. ASSESSING THE INFANT IN THE LIGHT OF ATTACHMENT AND CAREGIVING - RELATED ISSUES

a. When evaluating the infant, one has first to explore whether there is any attachment-related problem. Are the child's symptoms directly linked to a threat concerning accessibility to the attachment figure (Kobak & Esposito, 2004)?

Research has widened our palette of observation, with a new semiology that makes it possible to re-visit numerous symptoms, in particular out-of-control anger (tantrums), provocation and auto-aggressiveness, vicious circles in behavioral disorders, oppositional disorders, dysregulation of negative emotions, difficulty on the part of parents to set limits and cope with assertive behaviors (Lyons-Ruth & Spielman, 2004). We also pay a special attention to the history of the infant's attachment. We look for any early separation or loss and conditions in which they occur or for repeated affective ruptures with attachment figures (Boris, Fueyo & Zeanah, 1997)

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b. The assessment of the infant's attachment quality is one of the cornerstones of our clinical evaluation (Boris et al., 1997, Lieberman & Zeanah, 1999, Brisch, 2002, Crowell, 2003).

The parameters of the security base phenomenon and its developmental history are systematically explored: before 6 months, the patterns and behaviors of the pre-attachment period; around 8 to 10 months, the balance attachment/exploration with attachment figures; after the age of 2 years, autonomy and capacity for seeking help during exploration; from the age of 3 to 4 years, ability to negotiate, collaborate and to accept set limits. Finally signs of attachment disorganization, and for toddlers, controlling-punitive or controlling-caregiving behaviors are systematically looked for (Main & Solomon, 1990, Solomon & George, 1999)

Our attachment-informed assessment pays particular attention during the session (or in the waiting room and on the way to the consultation room) to the handling of distances and interpersonal orientation, to the child's reaction to reunion with caregivers after a mini-separation, to the child's reaction to stress when the caregiver is present, and to attention-seeking behaviors towards the caregiver. We also assess the resources that parents have available to respond to the attachment needs of their child, and how they can be used. The assessment is focused on the care-giving alliance with the partner, the existence of interpersonal demands that monopolise the attention of the parent, the presence of contextual stress which undermines the caregiver's security, and finally the appearance of "ghosts in the nursery" coming between parent and child. Does the child elicit in the parents' what Marvin called "their shark music" (2002), that means their own specific emotional interpretation of child's signals. The care-giving function is systematically assessed according to the level of stress (George & Solomon, 1999). The stress can be elicited by the clinical setting: for instance; evolution from the first encounter through the following ones, stress of the consultation by itself (limited time, contradictory demands). The caregiving function is also assessed according to the presence or absence of the other parent, when the child is present or not, according to the emotional register of the child (negative or positive emotion) (Kobak & Mandelbaum, 2003). This systematic assessment of attachment and caregiving-related issues at the individual, dyad, family and contextual levels makes it possible to identify possible focuses for an attachment-informed intervention (Belsky, 1999).

We emphasize that what we observe is informative only in relation to the context in which the observation is obtained. For instance, one has to define the level of contextual stress in which the observations are made, such as facing the unfamiliar first encounter, any separation or threat of separation, or the end of the consultation with the cleaning up phase. The expression and regulation mechanisms of positive emotions at low levels of stress can be observed, and likewise for negative emotions at higher levels of stress, as can needs for attachment or for exploration and self-assertion, according to the level of stress (Kobak & Esposito, 2004). Also, the observed behaviors are interpreted according to the interpersonal context, are they directed toward the attachment figure(s)?, or towards the clinician who is still a stranger for the infant? Who has brought the child? When there is only one parent, it is usually, the main attachment figure (Kobak & Esposito, 2004). As wrote Crowell (2003): "What are the child's behaviors? With whom? What behaviors are absent, and with whom? (Crowell, 2003)

c. Assessing the parent's representations of attachment leads on to the semiology of trans-generational issues.

Parental discourse when talking about any situation linked with the system of attachment during their childhood, is analysed with the semiology derived from the Adult Attachment Interview (AAI) (for instance coherence, quality of access to memories, discords observed between experiences linked to episodic memory and those linked to semantic memory, emotional expression, realistic evaluation of the past (Slade, 1999). Current parental attitudes towards attachment-relevant issues are systematically noticed: *"How important is attachment for the parents?, How important are relationships? How important are negative emotions (anger, sadness, fear)?*

We also pay attention to behavioral or emotional indices (we call them "infra verbal indices") each time there is an attachment relevant situation: parent's behavior toward the child, the clinician, the spouse; emotion expressiveness, tone of the voice (Slade, 2004). The reactions of the parents when the process of the consultation itself activates the system of attachment, (for instance the beginning and the end of the encounter, clinician's errors, delays, and interruptions in the session) also reveal their usual protective strategies (Holmes, 2001). The parents' history of attachment is cautiously and gently explored when possible. Is there any history of early separation or loss, repeated affective ruptures, maltreatment, sexual abuse, negligence (Slade, 1999)?

The quality of their present network of interpersonal support is systematically explored (Collins & Feeney, 2002).

d. The assessment of parents' caregiving systems: another cornerstone of our evaluation.

What does attachment-informed assessment show about the parents' interactions with their child?

The reasons for the parents' complaint or their visit, for instance doubts about their parental abilities or the presentation of the child's problem, can provide valuable information (Crowell, 2003). Parents of young children seeking help concerning their parenting difficulties may say some typical sentences which are really "warning" clues of transgenerational issues about attachment and caregiving (Guedéney N. cited in Braconnier et al., 2006). Here are several examples: Parents who do not feel the need to respond to vital needs of protection, closeness and security: *"Why is my baby crying? Why does my baby cling to me?"*; Parent who interprets the signals of

the baby in a surprising manner: *"He only does it to annoy me! It's all an act! It's capricious! "*; Parent who gives the response that seems the most appropriate, based on his or her own theory on what helps babies to grow up: *"You shouldn't be weak! You shouldn't get attached to people! You should be able to manage on your own! I never had anything and that didn't stop me from getting on! "*; Parent who lacks an "instruction manual" about parenthood or does not know how to prevent destiny when exposed to vulnerability: *"I would like you to have more than I had! Why aren't you well-behaved, docile or grateful like I was, even though I had nothing? Who's looking after me, a nostalgic and wounded child? I explode. I can't cope! How does a child think or feel?"*

The evaluation of the parental care-giving system also provides a new semiology for systemized observation (Fonagy et al., 2002, Cassidy et al., 2005, Slade, Sadler & Mayes, 2005, Koren-Karie, Oppenheim & Goldsmith, 2007):

1. Consistent and contingent response to the infant's attachment and exploration needs.

2. Identification of her/his distorted perception the child entertains of him/her as being non responsive.

3. Mirroring, reflective functioning and insightfulness capacities. In the case of parents of toddlers, we assess the quality of their goal-corrected partnership, their level of flexibility and quality of communication (Marvin & Britner, 1999).

4. Detection of parents' disorganizing behaviors, by using the paradigm of frightening/frightened behaviors from (Main & Hesse 1990, Lyons-Ruth & Spielman, 2004) and the abdicating behaviors from George & Solomon's work (1999). The observation of trans-generational transmission of disorganized attachment is striking while a coercive vicious circle starts up between the parent and the child, when the infant becomes more and more demanding, anger increasingly becomes mixed up with demands for comfort and the mother feels increasingly helpless, and angry (Lyons-Ruth & Spielman, 2004).

4. Our therapeutic application of attachment therapeutic programs (Holmes, 2001, Marvin et al., 2002, Kobak & Esposito, 2004, Lyons-Ruth & Spielman, 2004, Dozier, Lindhiem & Ackerman, 2005, Slade et al., 2005, Juffer, Bakermans-Kranenburg & Van IJzendoom, 2007).

"Caring for the caregiver" (Kobak & Mandelbaum, 2003). We must allow caregivers to retrieve their abilities to support and protect their child, or to use such abilities, where they do exist, in an efficient and "consistent" manner, while at the same time meeting their own unsatisfied needs for comfort and support. This can only occur on the basis of a therapeutic relationship which in itself is a vehicle for change.

The integration of an experience that is unlike the pattern that the parent has learned to expect from the world and from him/herself in a situation of stress gives that parent a chance to reassess all his or her previously working models through assimilation/accommodation processes (Mallinckrodt, 2000). Thus, focusing first on the caregivers' distress gives the therapist an opportunity to provide a corrective relational experience (Marvin et al., 2002) This new experience can give them the willingness for the process and to engage themselves because "they are worth it"

All the studies on the qualities of caregiving (Speltz, 1990, Fonagy et al., 2002, Kobak & Esposito, 2003, Lyons-Ruth & Spielman, 2004, Slade et al., 2005, Koren-Karie et al., 2007, in particular) give us a better understanding of how we can provide this secure base which also helps parents to explore the unknown.

The clinician has to use his or her mentalization abilities: the clinician can indeed simultaneously integrate the perspective of each member of the dyad/family, address both members of the dyad/family with the same attention, and communicate very quickly with each protagonist, in presence of both, on how they see this dual/trial perspective, all the while remaining emotionally involved. He/She has seen a behavior, has imagined the complexity of the motives underlying it, has contextualized the behavior, accepts what is shown without any negative judgment because he or she can imagine what each partner is feeling and has the conviction they are moving towards a solution.

The clinician gently and firmly assumes that it is he or she who is in a position to "lead the dance" of open communication in an emergent partnership, and in doing so, imagines what each partner is feeling and creates the conditions for a goal-corrected partnership (Marvin & Britner, 1999).

Emphasis put on the importance of open communication on the parent's negative emotions, whatever their object (healthcare setting, previous experience of assistance, professional's actions, or the child itself and parenthood) validates Fraiberg's intuition on the priority of working on what she termed the negative transference. Seeing the importance and the value that the clinician attaches to open communication about negative emotions is generally a very new experience for parents (Cooper et al., 2005).

This empathy towards the parent suffering as a parent is close to mirroring, because the clinician communicates at the same time the fact that he or she is confident that the parent will in the end be able to understand the child's behavior sufficiently for a positive relationship to develop, and that the clinician is there for that purpose. The recognition by the professional of any "technical" error from the reaction of the parent initiates the experience of a process of mismatch repair, unfamiliar to the insecure parent, but which contributes to developing trust and the feeling of worth for the Other.

Attachment informed intervention has the general goals of interrupting the symptomatic cycle in family relationships and of increasing the parent's acceptance of the child and the child's confidence in parent's availability. **Restoring the parent's**

sense of efficiency as a caregiver becomes essential.

Research on attachment has enriched our palette of interventions designed to improve parenting skills. Various applications can be used:

1. Sharing present-day knowledge on attachment and caregiving with the parents has become an essential step. Secure parents already have basic skills, but they may be inadequate for children with special needs; however for insecure parents these skills have been lost and for disorganized parents, these skills are not functional.

Five pieces of information have a particularly strong impact on parents. The human species is the only species that usually respond to a behavior according to the interpretation given to it and not only according to an automatic way. This notion introduces the idea that parents need to interpret the meaning *of their infant's behaviors, and hence the idea of representations underlying behaviors*. Reassuring parents that *the need for attachment*, i.e. seeking for proximity and comfort, is not only necessary, but the only possible means to provide the child with freedom to explore while still being connected with his/her caregiver. These same needs can underpin an openly rejecting, provocative, or distancing behavior on the part of the child and is often a very moving discovery for parents with a traumatic history of attachment or for parents with children with special needs. Helping the parents *to conceptualize the attachment domain separately from the domain of limits setting*, that has more to do with respecting the rights of others can contribute to separating the "strands of the knot" (Lyons-Ruth & Spielman, 2004) and to understand the "terrible twos". Explaining that *negative emotions* are a source of information and communication with others, and particularly sadness, fear and anger, is a very new information for non secure parents. Explaining in particular that anger is the strongest signal to remind the other of one's own importance, and what is expected of him or her, or to express disappointment at not having received what solely this other person could give, generally has a powerful impact on parents (Bowlby, 1988, Marvin et al., 2002). Anger and distress may be expressed or even exaggerated to signal to the parent that his/her attention and care are needed. Parental care is divided up into different dimensions: parents may love their child but be unable or lack the skill to respond to the child's needs for protection, comfort and security. Explaining *the role of interpersonal regulation*, showing the caregivers that their child, like all children, needs the caregiver to regulate and organise his or her negative experiences, is often very new information, especially if the child has special needs (Marvin et al., 2002). What can be traumatic for a child is not the negative emotion, it is to be suffering alone. Parents, accompanied by the professional, can more easily gain access to and reassess their IWMs of self and others, in attachment and in caregiving, in the light of this new information (Kobak & Mandelbaum, 2003).

The first issue is to draw the attention of the parent to the behaviors of the child and to the impact of the parent's own behaviors on the child, in a positive way. **For the parent in interaction with his/her child, attention to current infant's behaviors is now well known as buffering factor against an unwanted surge of unresolved parental affects** (Schuengel et al., 1999). This is a particular sort of attention, which the parent has rarely experienced in this form, since it is underpinned by the idea that a behavior always means something, but not necessarily what one thinks in the first instance.

2. Improving observation skills. Video techniques play an essential part, since they provide images that are different from those in the parent's mind (George Downing, personal communication); they operate at bodily and sensory levels, which probably have more impact on automatic parental functioning, thus facilitating re-evaluation of the IWMs. Discussion with the parent on his or her actions and the immediate impact on the child gives the opportunity for exchanges, and possible changes: showing that the impact of the parent's sensitive behavior on the child can reinforce the parent in responding appropriately and quickly to the child's signals (Marvin et al., 2002).

3. Developing parents' reflective skills. Work on representations is a way to come to understand what gets in the way of a parent's ability to form a secure base or a partnership with their child: this is not solving the parent's relevant attachment issues but making them improve their caregiving by giving meaning to what has seemed, up to then, to carry nothing but failure, incomprehension, anger and helplessness (Lyons-Ruth & Spielman, 2004). Three levels can be elicited. Firstly we can explore parent's own theory about caregiving: *how does each parent think that one should respond to the child's needs for protection and exploration?* (George & Solomon, 1999). Secondly we can explore the conscious representations of past memories, which can influence present behavior as a parent: *what are the memories of situations involving aloneness, vulnerability, sadness, anger, authority or comfort, with their own parents?* (Lieberman & Zeanah, 1999). Thirdly, we can go after the "ghosts" with new implements. For instance the *reframing* technique can capture unconscious representations that surge automatically in a parent and adversely affect their caregiving (Mallinckrodt, 2000, Marvin et al., 2002, Kobak & Esposito, 2004). Exploration of these representations can contribute to breaking the automatic pattern of procedures, and facilitate the parental reflective function (by intervening on exchanges that are "mis-cued", or that lead to a more defensive attitude). The clinician can use all these steps to improve the parent's ability to use his or her reflexive function to monitor, reassess and repair problematic communication with the child (Cooper et al., 2005).

4. Use of problem-solving techniques. Whatever the level of reflective processing, we wish to help parents to emerge from dilemmas by finding a "third way" (Lyons-Ruth & Spielman, 2004). The use of clinical vignettes from the day routine or use of video clips, heightens a parent's ability

to monitor his/her communication with his/her child, to consider other alternatives, and to find opportunities for problem solving. This can improve the parents' sense of their own competence and trust in the child and in themselves. Negotiation, collaboration can contribute to developing new models for balancing the parent's own needs and those of the child and to reducing the antagonism between the parent's own attachment and caregiving systems (Lyons-Ruth & Spielman, 2004).

Clinical practice routine is different from protocol-based intervention studies. In clinical practice what matters is not "the group effect", but the individual family's commitment to treatment. We, as clinicians, use the research data as **guidelines for our attachment-focused intervention, whenever this is relevant**. Hence, we have learned to ask ourselves **"attachment-based" questions** whenever the family comes to us, such as the following ones: Is the situation one in which there is a risk of trans-generational transmission and non-security of the attachment (O'Connor & Zeanah, 2003)? Do we have to focus on disorganized attachment or to the lack of attachment relationships? Are the difficulties recent or long-standing? Or is it one in which the child has special needs (Juffer et al., 2007)? What motivational dilemmas are being played out for each protagonist? What is the level of distress in the relationship, from an overview of the strengths and vulnerabilities of the family (Greenberg, 2005)?

A working alliance (Bordin, 1979) is co constructed with each family. On what goals and on what tasks will they agree? Which problem is viewed by the parent as being the most urgent to solve? What is the key issue that would be the focus of the therapeutic work (the Linchpin, Marvin et al., 2002)? For instance, difficulties in limit setting associated with child's anger and defiance are indeed difficult to tolerate for parents. But for a parent with a traumatic attachment problem, that at least means that the repetition of his/her own past is stopped: the child is resisting and there will not be a further victim. Parents will accept to collaborate to change only if they are sure that to make their child able to accept boundaries will not mean for their child blackmail or submission.

To co construct the tasks to reach our common objectives takes account of three essential dimensions: 1. The parents' state of mind with respect to attachment gives us information about the risks of disclosure to each parent (Steele & Steele, 2003). 2. The parents' feed-back to our interventions about representations (Slade, 2004) allows us *"to approach parents the way they would want the parents to approach their children"* (Lyons-Ruth & Spielman, 2004). 3. Duration of treatment: in our system of care, there is no a priori time limit, and therefore the question is open for every single family (Cassidy et al., 2005). How long do we need to hold the newly acquired but still fragile parental caregiving quality? According to the attachment theory, parents would be those who indicate when they want to stop the process while being sure that the clinician will still be available in any case (Byng-Hall, 1991, Brisch, 2002). Indeed, based on our clinical experience, we need to be there for the first "relapse" that often comes after the initial improvement, in order to make the parents discover their real own competences.

CONCLUSION

We have described here how our clinical practice with families and toddlers in a Parisian community is informed by attachment theory, trying to show how basic research and intervention studies conducted all over the world can be integrated in each clinicians practice, wherever we work. If Fraiberg's work has shown us the ways we can help families, attachment theory gives us the one of the underlying theoretical frameworks which is necessary to allow us to develop our creativity on behalf of each individual family.

Nicole Guédeney, Unité de la petite Enfance, Institut Mutualiste Montsouris, Paris 75014,
Université Paris V René Descartes.

Antoine Guédeney, Service de Psychiatrie de l'Enfant et de l'Adolescent, Hôpital Xavier Bichat, AP HP Paris 75018, Université Paris VII Denis Diderot.

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Smell, Taste and Flavor

By
Peter J. Scheer, M.D. and Julie A. Mennella, Ph.D.

The chemical senses of taste and smell are crucial for survival since all animals depend on the consumption of nutrients. These senses evolved to reject that which is harmful and to seek out that which is beneficial and pleasurable. They are among the oldest, the most primitive and the least analytic of the senses. But perhaps their most significant contribution comes when the combine to form the flavor of the foods and beverages we ingest. As will be discussed, infants are born with the ability to taste and to smell and they rely on these senses to search for comfort and food. For infant mental health clinicians, the knowledge of the capabilities of infants and the frontiers of research on their development is important. As we learn about the sensory world of human infants, it will enhance our understanding and in turn, we will be able to advise parents correctly.

Although there are only a small number of primary taste qualities (e.g., sweet, salty, bitter, sour and savory tastes) which can be perceived in all areas of the tongue, olfactory sensations result from the activation of a thousand or more distinct types of chemical receptor proteins located on millions of receptor cells lining the upper recesses of the nose (Buck and Axel, 1991). The receptors for the olfactory system are stimulated when we inhale through our nose (orthonasal route) as well as when molecules reach the receptors by passing from the oral cavity through the nasal pharynx (retronasal route) when foods or liquids are in the mouth. This latter route, often referred to as retronasal olfaction, contributes more significantly than does taste to the complexity of flavor (Rozin, 1982). To demonstrate this, if you pinch your nostrils closed while eating you will interrupt retronasal olfaction and thereby eliminate many of the subtleties of food, leaving the taste components remaining. This is clearly noted by head cold sufferers who lose the ability to discriminate common foods when their olfactory receptors are blocked by a head cold. Similarly, foods often 'taste' better after a person quits smoking perhaps because their sense of smell has improved, allowing them to detect more subtleties of flavor.

The senses of taste and smell are quite developed before birth (see Ganchrow and Mennella, 2003 for review). That is, by the last trimester of pregnancy, the taste and olfactory