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Paediatric Feeding

by Dr. Tessa Taylor & Dr. Sarah Ann Taylor

What you might be seeing [1] Feeding difficulties come in many different forms. Children might only eat a narrow range of foods or limited variety (e.g., no vegetables or fruits), graze on snacks, or consume very specific textures or brands. Mealtimes may feel drawn out and involve children leaving the table, pushing plates away, or crying. You might notice difficulty chewing or swallowing, and foods might be spat out or held in the mouth for long periods. Children might not drink water from a cup, use utensils, or take their medication. They might depend on formula or a baby bottle, or a nasogastric (NG) tube or gastrostomy (G-tube). We have included a checklist of feeding difficulties to help identify when to seek support at the end of this article. Overall, it is important to know that you're not alone – feeding concerns like these are incredibly common in children (more common than autism; estimates up to 90% in developmental disabilities). However, this does not mean it is okay or cannot be helped.

Why might children have difficulties with feeding? Feeding difficulties are complex. Possible causes may be a combination of medical, skill, and environmental factors. Medical reasons can include having gastrointestinal issues (e.g., reflux), allergic reactions, difficulty swallowing, or complications from prematurity or genetic/developmental conditions. Skill and learning history factors might include delays (e.g., in chewing, cup drinking, using utensils), sensitivities due to lack of exposure, or lack of strength or coordination due to lack of learning practice. Added to these factors, children may have learned certain behaviours that work both to get their needs met (see below) and avoid and delay moving forward in feeding. Even once medical issues are resolved, children may still be unwilling to try new things and learn, or even if willing, they might not know how to eat and drink at an age-appropriate level.

Eating as a learned behaviour Eating (or, not eating) is a learned behaviour. How we respond to these behaviours as caregivers can really impact a child's eating. Research tells us that children refuse certain foods/drinks and engage in inappropriate mealtime behaviours to:

1) Avoid or delay an unpleasant experience; avoid the food or drink so they don't have to consume it
2) Get attention, interaction, or reactions from others
3) Get more preferred foods, drinks, or activities (e.g., snacks, juice, iPad, play)

To better understand, we can watch the child's meals and look for patterns. We take into consideration the child's point of view, looking at what happens when they do and don't eat or drink well. For example, if they refuse, do they get a break and the food is removed or meal ended? If they cry, do they get a cuddle or a song? If they spit out, do they get a food or drink they like better? If they cry or refuse, do they get toys or a video to distract them? Other areas to look at include the mealtime routine and set-up (e.g., amounts, textures), and the child's skills. Taken together, this creates a learning profile to better understand the child's needs. By focusing on what we can see in the here and now and rearranging the environment, we can find solutions to help children succeed and reduce stress in family mealtimes.

Let's not "wait and see": Seek effective help early [1] You may hear that children will "grow out of it," "eat if hungry," are fine if not underweight, or not "ready" for feeding intervention. Yet research suggests this is not the case, and in fact the problems can worsen over time. As a parent, it can be difficult to consider and prioritise all the goals children need to work on, and many professionals do not have specific expertise in feeding. However, it is critical to get effective help from feeding experts as early as possible. Eating and drinking are vital for children's nutrition and growth to support their learning and development. Feeding is also linked to many other important skills (e.g., communication, motor skills, toileting), and can set children up for success in other goals. Feeding supports allow children to participate in family and community life. Earlier services can be easier and quicker, and treatment options decrease with age. If you have feeding concerns for a child, you do not have to decide what to label it or whether it is severe enough before seeking help [2]*. Children need help if they are not *consuming* multiple foods from all food groups (protein, starch, vegetable, fruit), at age-appropriate textures and independence (self-feeding with utensils, self-drinking), or drinking water from an open cup. If these goals are not reached in therapy within a few weeks (or months at most), further help should be sought out.

Treatment that works [3-4] Behavioural feeding approaches have 50 years of strong evidence backing (the only well-established, empirically-supported treatment). They are effective for children with and without varied disabilities, even those who may have no verbal language and other skill delays. Treatments are also effective despite the original cause or diagnosis.* Behaviour-analytic feeding services require a high level of expertise and training from a specialised hospital in the United States, but are now available in-home in Australia and New Zealand [5, 6]. Because feeding difficulties can have multiple causes, evaluations by multiple professionals (e.g., gastroenterologist, allergist, speech pathologist for swallow safety, dietitian) are needed to ensure that medical/physical issues are addressed first. Critical to success is high family involvement, considering unique family dynamics and culture. Supports are data-driven and individualised, with a focus on direct work with the child. Approaches involve changing aspects of the mealtime environment or foods/drinks, such as providing incentives and positive interactions for swallowing, and setting small achievable mealtime requirements and gradually increasing them. Children may be provided with lots of choices to get the right balance of difficulty levels and incentives. Foods and drinks might continue to be presented, with instructions and guidance, and teaching of skills needed for age-appropriate meals. These approaches can all help children get over the hump of not wanting to try new mealtime tasks, and learn that it gets easier and they like more foods with practice and success. Services may need to be intensive (multiple meals per day for days in a row), but can work quickly (e.g., days, weeks), with big achievements. Caregivers receive lots of direct support to learn how to keep up the gains by themselves. If children are in therapy and the feeding concerns have not resolved (e.g., playing with, kissing, or talking about food but not actually eating it; working on junk foods or other tasks), they should promptly seek help from a specialised behaviour-analytic feeding provider. Research has found treatment reduces caregiver stress, can increase child happiness, does not negatively impact mother-child relationship/attachment quality, and positively impacts child emotional and behavioural functioning and quality of life; additionally, caregivers report high satisfaction and rate the treatment highly positively with no negative side effects in follow-up [7].

Conclusion Next to breathing, feeding is the first and most important thing we have to do in life, connected to almost every other aspect of a child's life and development. No human behaviour has greater biological and social significance. It occurs multiple times a day everyday and is one of parents' greatest responsibilities. Feeding difficulties are complex, and caregivers need the right professional help. Highly effective support is available, and can work quickly and have rippling positive effects into other areas for the child and family. With the right help, a child could learn to eat their birthday cake, go to overnight camp, take medicine by themselves, and/or join in the fun of family holiday traditions involving eating.

Resources

- https://www.kennedykrieger.org/patient-care/centers-and-programs/feeding-disorders-program
- https://www.paediatricfeedingintl.com/resources/ especially Videos/Easy Reads
- https://allyoucaneat.co.nz/family-resources
- Watch a free 25 min presentation video to learn more about feeding and in-home intensive intervention including tube weaning: https://www.youtube.com/embed/oqQN5X0WXHw
- https://www.theblendmag.com/ Issue 3, Pg 66 *Keen to wean?*
- https://www.venturapress.com.au/australian-autism-handbook 4th Ed., Ch. 12, Pg 172 *The big issues: Eating*

***Eating or Feeding Disorder? Avoidant/Restrictive Food Intake Disorder (ARFID)? Failure to Thrive? Picky Eater? Fussy Eating? Food Selectivity?** This can be confusing, but names change over time, differ between books and in research, and are mostly unimportant for feeding intervention with an exception: if the person has body image concerns (feelings/worries about their appearance/looks). To simplify, with body image concerns treatment falls under *eating* disorders (e.g., acceptance & commitment therapy/ACT), but without, under *feeding* disorders (behaviour-analytic treatment). ARFID is not "new," but more of a name change: Paediatric feeding disorders already have a well-established empirically-supported treatment (EST) dating back 50 years—you do not need to decide whether it is a disorder or which disorder it is, or if it is severe enough (e.g., is it picky or fussy eating or a feeding disorder?). This approach is individualised and simply focuses on each person's current specific feeding needs and goals (see the checklist) instead of labels. If the feeding problems are mild or caught early, services may just be easier and shorter. It is important to increase awareness of feeding treatment so children without body image concerns get timely evidence-based feeding instead of eating disorder interventions. Taylor, T., Haberlin, A., & Haberlin, J. (2019). Treatment of avoidant/restrictive food intake disorder for a teenager with typical development within the home setting in Australia. *Journal of Adolescence, 77*, 11-20. https://doi.org/10.1016/j.adolescence.2019.09.007.

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6. Taylor, T., N. Blampied, & N. Roglić, *Consecutive controlled case series demonstrates how parents can be trained to treat paediatric feeding disorders at home.* Acta Paediatrica, 2020. **110**(1): p. 149-157. Plain language summary: https://growkudos.com/publications/10.1111%25252Fapa.15372/reader & Taylor, T. & Taylor, S.A. Social validity of paediatric feeding treatment across goals, processes, and outcomes. *Child & Family Behavior Therapy, 2022, **44**(3), 213-240.*
7. Taylor, T., Phipps, L.E., Peterson, K.M., & Taylor, S.A. A systematic review and comprehensive discussion of social validity measurement in behavioural intervention for paediatric feeding disorders. *Submitted for publication, 2024.*

Scan or click for a checklist to determine your child's concerns and seek help

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Checklist: When you should seek further help (from 12 months of age)

Tick all that apply. Take this completed checklist along to your health appointment. Your child…*

Health

- ☐ Needs formula, supplements, or tube feeds** owing to lack of variety/intake
- ☐ Has frequent constipation (or dependent on laxatives) from deficiencies in diet and hydration
- ☐ Has identified delays in growth, or nutritional deficiencies
- ☐ Has low food intake, eating only a little, or skipping meals
- ☐ Refuses to drink enough water or milk/formula
- ☐ More dependent on liquids than eating solid foods
- ☐ Only eats snack (packet, dry, crunchy) or junk foods; grazes
- ☐ Does not eat from **all** food groups (foods hidden do not count)
  - ☐ Protein (meat, fish, nuts, beans, cheese)
  - ☐ Starch (breads, cereals, pastas, rice, potato)
  - ☐ Vegetable (cucumber, broccoli, avocado, celery, carrot, beetroot, pumpkin)
  - ☐ Fruit (melons, apple, banana, berries, stone fruits)
- ☐ Refuses supplements or medication

Skill and Independence

- ☐ Still drinks from a baby bottle at >18 months age
- ☐ Has difficulty chewing or swallowing, may include holding foods for long periods, gagging, or coughing
- ☐ Does not eat age-appropriate textures (e.g., relying on food to be mashed/pureed)
- ☐ Does not have independence with drinking expected at age (open cup by themselves)
- ☐ Does not have independence with eating expected at age (full utensil use, food has to be cut up)

Behaviour and Social

- ☐ Requires separate foods from the family
- ☐ Engages in inappropriate mealtime behaviours such as crying, negative statements, turning head, covering mouth, hitting items, spitting out food, aggression, hurting self, leaving table
- ☐ Has lengthy mealtimes (over 20 minutes)
- ☐ Only consumes food or drink at certain temperatures, prepared a certain way, specific brands, colours, or in certain receptacles/utensils
- ☐ Only eats in certain settings (e.g., home), at certain times, or with certain people (e.g., mum)
- ☐ Requires “distractions” to stay sitting or eat (e.g., TV on during meals, attention)
- ☐ Refuses to sit at table for meals
- ☐ You are feeling high levels of stress, such as dreading mealtimes

*If not explained by another event (e.g., dental, ill or recovering, environment change) and persists (e.g., occur a few times a week for a few months, or occurring daily over 3 weeks). You may already have tried general recommendations/strategies without success, and mealtimes are creating stress at home or you’ve changed aspects of the meal to avoid it happening.

**If on tube feeds (gastrostomy, nasogastric [NG] tube), has clearance to eat or drink orally/swallow safely (or, to work towards swallow evaluation).

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