# Eating problems in young children

*Jo Douglas*

***Over the past 10 years, there has been increasing recognition of the importance of eating problems in young children. Paediatricians are now also recognizing the importance of managing this problem in the context of a wide range of medical disorders. Multidisciplinary assessment and treatment is essential to manage the wide variety of childhood eating problems.***

Food refusal in young children includes a varied presentation of problems. Children may be severely selective in their diet over several years; refuse complex textures of food and remain on puréed diets; gag, spit and vomit; have a very small appetite and may fail to thrive. The incidence of early childhood eating problems in the general population ranges from 25–35% (Linscheid et al, 1995), although the incidence of failure to thrive is about 3.5–5% (Skuse, 1993).

## FAILURE TO THRIVE

A child who is failing to thrive is more than two standard deviations below the norm for weight, corrected for gestational age, parental growth patterns and gender. A deceleration in rate of weight gain showing a progressive weight loss across at least two percentile bands is also used as a diagnostic indicator (Skuse, 1993; Batchelor, 1999). However, strict adherence to these diagnostic criteria of weight only can miss significant feeding and eating problems in young children that cause considerable long-term distress to both children and parents.

Failure to thrive and eating problems should be viewed as overlapping conditions, and eating problems should be viewed as valid concerns even if the child is not failing to thrive. Some parents exert so much effort in getting their child to eat that they can disguise the severity of the problem if it is assessed solely on the basis of the child's weight.

In most cases, the parents are concerned and seek help with their child's eating problem or weight loss, but a small proportion of parents is unwilling or unable to recognize the severity of the problem. Social services may be required to support health professionals and help the parents in accessing treatment for their child.

## DIAGNOSTIC DICHOTOMIES

The diagnostic dichotomy that developed between organic and non-organic failure to thrive has now been considered to be generally unhelpful, and it is now more useful to consider children's eating problems as the result of a unique combination of physical and environmental influences (Homer and Ludwig, 1981; Boddy and Skuse, 1994; Manikam and Perman, 2000).

Young children with severe and chronic eating problems and/or failure to thrive often have multiple problems with more than one cause. The interaction between these causes requires a multidisciplinary approach for the assessment and management of complex and severe cases. The continued engagement of all of the clinicians is important in monitoring progress. The worst scenario is when children are bounced between medical and psychosocial services, each demanding that the other service should solve the problem.

## DEVELOPMENTAL CONTEXT

Eating problems occur in a changing developmental context. The growing infant passes through different stages of eating during the first couple of years of life, and problems can occur at all of the transitional points: weaning from the breast or bottle, moving from puréed to lumpy foods, introducing finger foods, learning the autonomy in self-feeding. The parents also have to learn how to cope with the changing needs of their infant and how to facilitate these transition points.

## AETIOLOGY

### Physical influences

The physical influences on the development of a child's eating can be very significant. A wide variety of medical conditions affect a child's appetite and his or her ability to eat (Douglas and Bryon, 1996; Harris et al, 2000).

Gastroenterological problems commonly include gastro-oesophageal reflux, oesophageal

**Mrs Jo Douglas** is Consultant Clinical Psychologist (child), Ladymead, Loudwater Heights, Rickmansworth, Herts WD3 4AX, and was previously Head of Psychology Services and Director of the Day Center Feeding Programme, Department of Psychological Medicine, Great Ormond Street NHS Trust, London

dysmotility, constipation, slow stomach emptying and oesophageal abnormalities (Mathisen et al, 1999). Low birthweight and prematurity appear to be risk factors in the development of eating problems (Douglas and Bryon, 1996). Similarly, disorders affecting the metabolic rate also affect appetite; heart disease, renal failure, diabetes and cystic fibrosis all have a significant impact on how the child eats (Thommessen et al, 1992; Sanders et al, 1997).

In addition, neurological difficulties that manifest as oral motor delay or dysfunction impact on how able the child is to cope with changing textures of foods (Reilly et al, 2000a,b). Initial problems with coordinating swallowing, breathing and sucking can establish problematic feeding interactions with the mother. Later refusal to progress on to mixed or more solid textures of food because of problems coordinating chewing and swallowing can create a significant problem, even though weight is being maintained.

### Tube feeding

The use of tube feeding as part of the medical management of many children's illnesses can create problems as well as ameliorate others (Douglas and Bryon, 1996). The psychological management of long-term tube feeding is an important element in planning its eventual removal. Its advantage in reducing the anxiety and concern about a child who cannot or will not eat is immense, but it should only be seen as one step on the way to helping the child manage to eat orally (Basyk, 1990). Early oral motor intervention can help decrease the length of transition from tube to oral feeding. Non-nutritive sucking during tube feeding has been shown to be valuable in this transition and to decrease the length of hospital stay (Bernbaum et al, 1983).

There are differing views on how to gradually reduce the child's dependency on tube feeds and replace them with oral feeds. The overall aim is to increase the child's appetite by reducing tube feeds but not to compromise weight gain. Whether this is best managed by restricting tube feeds into a daytime meal pattern or by moving them over night and allowing the daytime for oral feeding has not yet been clarified. However, the behavioural management of the child as he or she learns to eat orally again is a vital part of the programme of change (Schauster and Dwyer, 1996).

## SOCIAL AND BEHAVIOURAL INFLUENCES

A child who feels nauseous while eating, regularly vomits after meals, feels satiated rapidly or chokes when eating will have repeated aversive learning experiences and will start to avoid food (Douglas and Bryon, 1996). Parents then become anxious and may be placed under pressure from health professionals to increase their child's weight without any help and guidance in how to do this. The stress that this can generate in families is immense. Dysfunctional patterns of behaviour can rapidly escalate, with parents threatening or punishing the child, starving the child until they eat what is expected or forcing the child to eat. Failure of these techniques often results in parents giving up and allowing the child to eat exactly what they want with the hope that at least they will gain some weight. Other parents excessively cajole their child, play games, do not allow their child to self-feed or distract them with stories, toys and television while putting food into their child's mouth.

The behavioural management of the child around food and meals can exacerbate or ameliorate some of the physical elements that the child is experiencing (Stark et al, 1994). Parents who feel frustrated, angry and stressed may lose their tempers and create more stress for the child, which can compound the aversive experience of eating and meal times.

The parents' own emotional state will impact on how they manage their child. Depression and hopelessness may lead to detachment; anxiety and stress may lead to pressure and over-involvement. They may be unable to support their child emotionally or be emotionally volatile and unpredictable themselves. In some families, the parents' own childhood experiences will affect their ability to cope generally with being parents. They may be neglectful, abusive, punitive or restrictive in their own feeding practices (Chatoor et al, 1998).

In some cases, the original aetiology of the feeding problem may have been superceded by the emotional and behavioural components. The maintaining factors of the child's feeding problem have become paramount. When parents are unable to establish appropriate boundaries for their child's behaviour, distorted eating patterns can continue for many years (Douglas, 2002).

## ASSESSMENT AND TREATMENT

Observation of a meal together with a full medical, eating and psychosocial history, plus a food diary to assess current oral intake over 3 days, provides a psychosocial assessment that complements the medical assessment. A multidisciplinary approach requires close liaison between paediatricians and psychosocial services. Speech and language therapists and dieticians also have an important role in the team, the precise combination of professionals required depending on

the type of problem presented. The child's experience and behaviour needs to be understood as well as that of the parents.

## OBSERVATION OF A MEAL TIME

Observing a meal time is crucial to understanding the parent–child interaction that develops around eating. The details of the interaction and the emotional tone are difficult to assess accurately from interview alone. Observation of the child's attitude to the food presented, appetite, attempts to self-feed, type of avoidance, emotional state, persistence, concentration, ability to cope with textures and oral motor skills provides a guide to areas of intervention. Similarly, observation of the parent's emotional state, behavioural response to the child, management skills, what they offer the child to eat, the quantity they expect their child to eat, timing and reciprocity gives an understanding of the effect of the child's problem on the parents. There are a number of different methods for coding and analysing this interaction (Sanders et al, 1993; Werle et al, 1993).

### Treatment programmes

Psychologically based treatment programmes have developed over recent years, and the importance of this work has been clinically proven (Linscheid et al, 1995; Douglas and Harris, 2001). The reported programmes in the US tend to be inpatient based, but these problems can also be managed on an outpatient basis or in the child's home (Batchelor, 1999).

Psychosocial treatment approaches will vary according to the factors that are maintaining the eating problem. If the child is fearful and anxious about eating as a result of previous aversive learning, desensitization approaches aimed at reducing the child's anxiety but still presenting change in a gradual and systematic manner will be most successful. If the child is still experiencing unpleasant sensations while eating as a result of his or her medical condition, psychological approaches are unlikely to have much impact, so continued liaison between clinicians is essential in order to maximally help the child.

Encouraging children to take greater control in self-feeding also reduces anxiety and gives them some confidence in a situation where they feel vulnerable and uncertain. Managing the timing of meals, the size of portions offered and the types and textures of foods offered can all improve a child's eating pattern.

Parents often need help in understanding their child's reactions, in learning how best to manage him or her and to set clear limits that enable the child to broaden his or her experience. Children who are very controlling in what they will and will not eat may be anxious or manipulative. Behavioural management techniques that employ reinforcers for appropriate behaviour and ignoring inappropriate behaviour have been very successful.

Parents themselves may need an opportunity to understand their own emotional reactions to the problem. They may need time to learn how to work together and support each other during times of change. An atmosphere of blame and criticism needs to be replaced with joint planning, problem solving and coping. Building up the child's self-confidence with eating and self-esteem will increase their motivation to cope with change. Play allows children to try out and practice skills relevant to eating; messy play in particular helps children who are concerned about sticky fingers to tolerate picking up food with their hands (Douglas and Harris, 2001).

## KEY POINTS

- Failure to thrive should not be the only diagnostic criteria for the assessment of eating problems in young children.
- Eating problems and failure to thrive are overlapping conditions.
- Transitional points in the development of learning to eat can cause problems.
- Both organic and psychological influences interact in the development of eating problems.
- Multidisciplinary assessment is important in managing eating problems.
- Observation of a meal time is an essential part of assessment.
- Parents require psychological guidance in how to manage their children's eating problems.
- Behavioural management techniques that help the child relearn how to eat are effective.
- Children's and parents' anxiety needs to be reduced in order for effective learning to take place.

## THE FUTURE

Eating problems in young children are an important area of concern and treatment, both in hospitals and in the community. We must be wary of anecdotal and simplistic views about managing these often very complex problems. The literature is often confusing, as the term 'eating problems' can cover a wide range and differing severity of problems, some of which can be adequately managed in the community by primary health-care professionals, while others require complex multidisciplinary teams and an inpatient or daycare setting.

Long-term follow-up for the management of these cases is not evident in the literature; neither is the natural course of early childhood

eating problems. Part of the difficulty is in creating a simple classification. The interaction of factors that contribute to the aetiology and maintenance of these problems is complex and often highly specific (Burklow et al, 1998). This is an area where medical and psychological services need to work closely and cooperatively. HM

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