

Children With Feeding Problems Require "Multi-Course" Approach To Treatment

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Working with infants and children with feeding problems requires specialized training and advanced coursework. Services are typically provided by an occupational therapist or speech language pathologist. In some cases psychologists and behavioral therapists may provide treatment when the problem is related to behavioral challenges. For the purpose of this article the focus is on children who require evaluation and services from a therapist trained in feeding- and swallowing-related disorders.

What does a parent do when a child refuses food, has a limited diet, or is having difficulty managing food or liquids? Children are referred for feeding problems for a variety of reasons and underlying diagnoses but generally they present with:

- Poor growth, failure to thrive or nutritional deficiencies
- Obesity related to limited diet and foods high in fat or carbohydrates
- Difficulty handling liquids or food due to oral motor, swallowing or structural deficits (there may be a history of aspiration)
- Oral aversion, sensory defensiveness, or pain
- Mealtime struggles, food refusals, avoidance behaviors

There are a host of reasons these problems may develop. Each child is evaluated by obtaining a careful medical, development and feeding history dating back to infancy; doing an oral motor, reflex and sensory examination; functional observation of bolus

control and swallowing; and observing the child eating and/or being fed typical food as well as attempts at trying a new food.

The feeding history includes information about the current problem, the course of events leading up to the problem, the child's appetite, and typical diet and schedule for mealtimes. Does the child "graze" all day, sit for meals, fill up on snacks or fill up on liquids throughout the day?

Information is obtained on general medical and developmental conditions, allergies, respiratory or cardiac-related problems, medical conditions, oral care and hygiene, special dietary requirements, elimination habits, gastrointestinal history, skin rashes, sleep patterns and/or problems with snoring, and general behavior and compliance in other areas of daily life.

Parent goals, concerns and personal expectations are also important considerations in the assessment process. Key to a successful assessment is to listen carefully and to expand on relevant comments, as this information can often indicate factors that are contributing to the problem. Parents must be involved and committed to carrying over recommendations or it is very difficult to make changes.

In an outpatient setting, children are required to have a prescription from a physician - typically a pediatrician, gastroenterologist, otolaryngologist, pulmonologist, psychiatrist or neurologist. However, a referral for services may come from any number of sources including dietitians, therapists, nurses, psychologists, community agencies, early intervention, schools, insurance companies and word of mouth.

At Braintree Rehabilitation Hospital in Braintree, MA, children are scheduled for an initial appointment to gather background information, evaluate the child, and discuss

parental concerns. A plan is subsequently formulated for each child based on the findings; typically children come for services 1-2 times a week. An evaluation includes history, objective observations, summary and impressions, a treatment plan if warranted, and any additional recommendations based on findings. If further assessment of swallowing function, such as a modified barium swallow study (MBS), is recommended, then the child is typically referred to one of the area hospitals, and information regarding observations and concerns is provided to the specialist who will be performing the test.

It should be noted that by the time most children (other than infants) are referred for a feeding evaluation, the problem is already well-established. Part of the evaluation is "teasing out" contributing factors to the feeding problem and if other consultations may be needed. Children with feeding problems often have more than one issue that has led to the difficulties. Some of these issues may be apparent during the evaluation, but sometimes they do not become obvious until the child is observed across several treatment sessions. For example, sporadic difficulty with breathing when eating or gulping when swallowing may not occur at every meal but once observed the parent will often corroborate that this occurs regularly and they can elaborate on when it occurs in relation to eating. This may warrant further consultation from an otolaryngologist, gastroenterologist or other team member depending on what is observed.

Treatment strategies vary depending on each child's individual needs, age and clinical findings. Treatment typically includes several approaches including oral motor training and exercises; oral sensory input to either heighten awareness or decrease sensitivity or gag reflex; texture progression; modifications to foods and liquids as needed due to oral motor control and for safe swallowing; sensory-behavioral strategies;

analyzing food and its properties to facilitate introduction of new foods based on the child's preferences; training the child to use steps to trying a new food; behavioral rewards and strategies; positioning; self feeding; equipment; and parent education.

Also important in the treatment process - especially when a child is advancing off tube feedings and/or has growth problems - is the caloric density of foods, caloric intake, hydration, and administration of medicine. When a child is advancing off tube feedings it is done in conjunction with the dietician and physician to be sure the child is getting the right nutritional balance, hydration and calories needed for growth, and for his or her medical needs. I am an advocate for children eating healthy whole foods and providing the parent with resources and education about food labels and ingredients. Unfortunately, many children are eating processed and fast foods, and when combined with a limited diet selection they are not getting adequate healthy nutrition.

Except on rare occasions, I will not use any foods as reinforcements for good eating as most children will typically respond to other positive rewards. If a food must be used, it is typically done with the idea of *first* a bite of this and *then* a bite of the preferred food to diminish the notion that it is a reward. Treatment sessions are set up to be fun and positive. In this setting the child is seen most of the time on a 1-to-1 basis. However, when appropriate I have also used a self-pay group model one time a week for 6-8 weeks based on themes and activities related to the food items. Some insurance companies will not cover the group model, so this is a consideration in treatment planning. Sometimes a sibling may participate in some of the sessions when a group is not feasible and if the child would benefit from a peer model.

When working with a child with feeding problems one encounters many underlying diagnoses and problems that can have an effect on a child's eating. Some of these conditions may be progressive; in other cases the child is stable but having issues with eating. Primary diagnoses can be from a wide variety of conditions including congenital, neurological, muscular, metabolic, gastrointestinal, cardiac, pulmonary and airway problems, facial-neck-oral problems, cancer, immune disorders, autism and related conditions, dyspraxia, sensory processing problems, failure to thrive, obesity and phobias that impact eating.

The Primary Diagnosis should include related conditions such as gastrointestinal reflux, gastroenteritis, esophagitis, laryngeal cleft, autism, cerebral palsy, and Down syndrome, to name a few. The Treating Diagnosis is currently classified under ICD 9 codes but will be changing with the introduction of ICD 10. The current common Treating Diagnosis includes Feeding Disorder, Failure to Thrive, and Dysphagia, which can be further broken down in to oral, pharyngeal and pharyngeal-esophageal. Treatment is tailored to primary and treating diagnosis, parent's and/or the child's (when old enough) concerns and goals, and identified problems and clinical findings from the evaluation. Additional work-up may be indicated, most typically a consult with a gastroenterologist or otolaryngologist. The child may also be receiving services through early intervention or in the school so services and recommendations may be coordinated and facilitated across different settings. In addition, many of these children are receiving or are in need of other therapy services.

At Braintree Rehabilitation Hospital care can be coordinated with several pediatric services including physical therapy, occupational therapy, speech therapy,

physiatry and neuropsychology. On rare occasions, children who are not able to progress in an outpatient setting may be referred to a day or inpatient program which affords the intensity that some children need. They are then able to return after the initial inpatient program for additional treatment to further advance their oral motor skills, texture progression and self feeding.

There has been an increase in children with feeding issues, some of which is due to better recognition and referral for the problem. However also correlating with the increase in children with feeding issues is the rise in other childhood disorders such as autism, gastrointestinal disorders, allergies/food sensitivities, and autoimmune disorders - conditions which often exacerbate feeding issues. This is partly due to the medical advancements which allow survival of more premature and medically fragile babies.

In addition, our culture has changed with the increased availability of quick and processed foods, busy schedules interfering with families having sit-down meals, and children having more say in what they will eat. Many parents report that they make separate meals for each family member, which limits the child's exposure to new foods and often enables the child to continue a limited diet. It is not unusual to have normal developmental stages when children become picky or go through phases where they prefer to eat certain foods. However, these phases are short-lived and typically not so limiting that a child will refuse to try a different brand or food.

The challenge comes from the child who develops avoidance behaviors, food refusals and rituals around presentation of their food. This is the child who will only eat one brand of chicken nugget - probably cooked a specific way - and may not accept another food on the same plate. This child typically has only a few foods which may be

further limited by brand, texture, color, feel and presentation. Often these children have difficulty in social eating situations as they only want the familiar foods. They may not eat in a restaurant, at school or a friend's house.

Unlike the picky eater they may have nutritional deficiencies due to the limited diet. Working with these children most often entails changes not only in the child but in the child's parent and family dynamics. These children often have no idea about how to try a different food and become anxious at the thought of it. I have had success in helping children break down the steps to tasting food into simple sensory components and providing reinforcement for even the smallest steps. However, critical to the child's progress is the ability and willingness of the parents to make changes to their behavior and to set new expectations for family meal times. This is often a gradual process with changes taking place with both the child and caregivers.

Working with children with feeding problems is most often multifaceted, complex and both rewarding and extremely challenging. It is important to have a network of specialists to consult with, as the majority of these children have other issues contributing to the problem. For the most part, the notion that children will eat when they are hungry does not work for this group. They often are not driven by an interest in food, and their avoidance behaviors or reasons for not eating are often well-established. Sometimes the child does not have the oral motor control, chewing skills, ability to control some food or liquid consistencies or swallowing ability - all of which may limit their diet. In other cases it may be the smell or sensation of food that is limiting the child. It may be an experience a child had when eating, or that when they eat they feel pain or their breathing is compromised.

When working with these children, parents and families must be good at observing and listening - at times being a detective - as well as possess patience and sensitivity while being clear about the objectives and goals to keep the child advancing. I have had the most rewarding and the most challenging experiences working with these children. The ultimate reward is seeing children take their first bites of food when all they knew was being fed by a tube; the child who has learned to use steps to trying a food and is no longer anxious and tearful around meal times; the child who has learned to chew and manage solids when all they were able to eat was baby food; the child who has started to learn to feed themselves and is becoming more independent; the child who is no longer fearful of eating because of gagging, choking or pain; and the child who now eats healthy and nutritious foods. As a feeding therapist you have the opportunity to change a life; that is a reward whose value cannot be overstated.

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