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Pediatric Feeding Disorders Overview

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Agenda

- Introduction to feeding
- Feeding myths
- Research and background information
- Mealtime and other goals
- Strategies for teaching
- Questions
Learning Objectives

- Participants will be able to identify appropriate goals to treat feeding disorders
- Participants will be able to identify evidence based teaching strategies related to feeding for use in clinical practice.
- Participants will be able to identify how behavior analysts and occupational therapists can work together to help children increase oral consumption.

Feeding is Complex

- Organs
- Muscles
- Senses
- Developmental level
- Medical history and present status
- Learning history / style / capacity
- Nutritional status / history
- Culture
- Environment
Sensory Processing

- Eat is not as simple as “sit down and eat” for children with autism
- Lights
- Number of people at the table
- Aroma of the child food or food around him or her
- The food texture to his or her hands and mouth
- The feeling of the chair or child’s clothing

Prevalence

- Prevalence of feeding and swallowing problems:
  - 25-45% of ALL children
  - 30-80% of all children with a developmental disability
- Prevalence of significant feeding problems:
  - 3-10% of all children
  - 26-90% of children with physical disabilities
  - 10-49% of children with medical illnesses and prematurity
Important Implications

Long-term chronic feeding problems are associated with:
- Health risks for the child
- Increased perceived stress for the child and family
- Mental health problems in families
- Increased risk of developing eating disorders like anorexia
- Increased health care costs for the child and family
- G-Tube Cost Approximately $41,811 for the first year

Therefore, treatment of pediatric feeding problems can result in:
- Improved health of the child
- Improved quality of life for the child and family
- Decreased mental health problems in families
- Reduced risk of long-term eating problems
- Reduced health care costs

Feeding Myths

- Eating is the body's number one priority
- A child will not starve himself
- Eating is instinctive
- Eating is easy
- Eating is a 2 step process (sit down & eat)
- It's not ok to play with your food
- Children only need to eat 3 times a day
- If a child won't eat they either have a behavioral or an organic problem (it can be both!)
- Certain foods are only to be eaten at certain times of the day
- Mealtimes are a proper social occasion. Children are to “mind their manners”
The Struggle…

- Have you ever met a child who...
  - Will only eat foods that are white or tan in color?
  - Won’t eat food if it touches another item on the plate?
  - Sees a string on his banana and cries like you chopped off his leg?
  - Will only eat green beans if the seeds are picked out from each and every one and removed from the plate?
  - Won’t eat meat, unless it’s a cold hot dog, and you must call it a cold dog because if the child hears the words hot dog, he won’t even touch it to find out it’s actually cold?

When is help needed?

- Types of reasons families seek treatment for their child:
  - Failure to thrive
  - Food selectivity
  - Maladaptive behaviors at mealtime
  - Medical issues early on prevented age typical eating patterns to emerge
  - Change in eating habits (frequency, variety, quantity)
  - Overeating
  - Unable to chew
  - Swallowing problems
Why ABA?

- Medical can often lead to learned behaviors
  - Child engages in mealtime behaviors that are reinforced through either:
    - Positive Reinforcement (given tangible items as rewards, preferred foods presented, parents put on a song and dance)
    - Negative Reinforcement (nonpreferred foods get taken away, release from the high chair when parent “gives up”)

Prior to Treatment

- All children should be medically cleared prior to beginning treatment
  - GI concerns identified (e.g., constipation, diarrhea, delayed gastric emptying/motility problems, GERD)
  - Allergies
  - Aspiration risks
  - Dental concerns
  - Barium Swallow Study completed
  - Metabolic disorders
Mealtime Goals

- Medically Focused Goals
  - Increase weight
  - Increase PO intake
  - Decrease G-tube/bottle dependence
  - Assessment and reduction of mealtime emesis (vomiting)

Meal Time Goals

- Non-Medical Concerns
  - Decrease mealtime inappropriate behaviors
  - The child will eat age-appropriate foods
  - The child will participate in meal time with the family
  - Child will eat a variety of foods (typically eats same exact meal every day or he does not eat)
  - The child will break ritualistic behaviors surrounding meal times (e.g., same cup, same bowl, only certain brands of foods, only eats if in special chair)
  - The “happy meal” goal – the child can eat out with the family or at a birthday party without engaging in maladaptive behaviors
Meal Time Goals

- Meal time is full of teachable moments!
  - Unpacking and opening/closing containers
  - Eating a variety of foods
  - Drinking from a cup
  - Napkin use
  - Utensil use
  - Bowl versus Plate use
  - Cleaning up

Expectations of Children

- Eating
  - What to eat off of:
    - Plate
    - Bowl
    - Modified bowl
  - What to eat with:
    - Fork
    - Spoon
    - Modified fork/spoon
Expectations of Children

- Drinking
  - Open cup
  - Nosey cup
  - Straw with open cup
  - Straw with closed cup
  - Straw in juice box
  - Sippy cup
  - Bottle

Additional Goals

- Social aspects
  - Conversation
  - Picking a restaurant
  - Birthday parties

- What NOT to do:
  - We can not force a child to eat food – Aspiration risks
  - We can not physically restrain a child in any way in order to force them to eat.
Ineffective Strategies

- From the below listed strategies caregivers use, 67% of the children actually worsened their behaviors:
  - Distracting
  - Coaxing
  - Reprimanding
  - Allowing periodic or longer breaks
  - Providing preferred food or toys
  - Discontinuing the meal

Evidence Based Practices

- Summary of Review Paper
  - Treatments proven effective:
    - Escape Extinction
    - Differential Reinforcement
    - Noncontingent Access
    - Antecedent manipulations (e.g., texture, bite size, utensil type)
Stages of Sensory Development for Eating

- Acceptance
- Touch
- Smell
- Taste
- Eating new foods

Foundation Skills

- The key to teaching a new skill revolves around:
  - Attending skills
  - Building Rapport
  - Gaining instructional control
Strategies

- Provide appropriate positioning for feeding
- Shaping
  - Baby steps
  - Rule of 3
  - Follow through on all demands
  - End on a positive note

Case Study
Case Study, cont’d

ABA and OT

- Collaboration is key
- A BCBA can assist with:
  - Identifying the function of mealtime behaviors
  - Instructional control
  - Reinforcement schedules
- An OT can assist with:
  - Motor concerns
  - Sensory aversions
  - Adaptations or Modifications
Evidence Based Practice

- Two common treatments for feeding disorders include:
  - The SOS (Sequential Oral Sensory) Approach
  - Applied Behavior Analysis

- First study to attempt to compare the effectiveness of each:

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Case Study: White Bias

- 4-year old male
- Typical development with diagnosis of food aversion
- Liquids: Whole Milk, Publix Gallon Size, in a bottle
- Solids: Swiss Miss Vanilla Pudding, Pringles Original Chips, Snyder’s Pretzel Rods
Thank you!

- References:
  - Piazza, C.C. (Unknown). Treatment of pediatric feeding disorders: What you don’t know may hurt someone. University of Nebraska Medical Center’s Munroe-Meyer Institute.

Questions?

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