Clinical intervention for feeding difficulties in early infancy

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What are the early feeding problems?

- Identified through screening of infants in the “well baby clinic”
- Instead of waiting for a pediatric referral, early identification and early intervention
- Settings: Breastfeeding Clinic. Pediatric setting and
- Health department (WIC program)
What is the meaning of an eating problem?

- They can exist as the “only problem” or

- They are often a “marker” of other difficulties in the baby

- These difficulties interact with the caregiving practices of the parent, i.e. whether parent is already vulnerable, problem solving abilities, capacity to read the baby, etc.
Types of difficulties

- **I First few months of life**
- **Problems in state organization, e.g.**
  - Tendency to fall asleep and sucking ability
- Tendency to want frequent small “meals”
- Becoming tired and unable to continue sucking
- Problems in sucking
Types of difficulties

After four/five months of age

Problems in self-regulation and focus
Difficulties in maintaining focus on eating
High sensitivity to stimuli, interpersonal and sensory (auditory, visual, etc.)
Other problems in self-regulation (e.g., level of activity, irritability, sleeping difficulty.)
Types of difficulties

**Toward the end of the first year of life.**

**III Difficulty with the progression of feeding abilities**

- Child is unable to accept foods other than liquids
- Unable to tolerate textures, flavors, odors, etc.
- Restricted range
- May not get enough calories..
- Baby has more voluntary behavior, refusal
Types of difficulties

Older infant

IV. Others, including Rumination, Pica

Self-induced vomiting is not so rare

Pica is not so rare (?)

Maturational abilities of the child to organize adequate feeding behaviors in the context of relationships and caregiving.
How does a clinician intervene with a feeding problem?

- **HISTORICAL INFORMATION**, history of eating and other aspects of child’s life and functioning
- Detailed account by the caregiver regarding eating behavior (on the part of the infant and of the caregiver)
- Other history of development
Evaluation of eating behavior?

- Current/history appetite problems?
- Current/history feeding skills problems?
- Current/history vomiting, regurgitation?
- Current/history of interest in food and in the mealtime
- Current/history of problems in sucking, munching, chewing, deglutition?
How does a clinician intervene?

**DETAILED OBSERVATION** of the *Mealtime* interaction (e.g. breastfeeding)

As “naturalistic” as possible, e.g. home visit or video of home feeding

Observe the interactions and “dance” of feeding between infant and caregiver

Possible: clinician trying to feed baby
How does a clinician intervene?

ASSESSMENT OF THE **TOTAL CHILD**

Direct observation and interaction with the baby in other areas:

Motor abilities, quality of movement, motor coordination, muscular tone overall, level of energy, whether adventitious movements, motor functioning of mouth, tongue, chewing, etc.
How does a clinician intervene?

Other factors that may impede eating:
- Architecture of the oral cavity
- Movement of tongue, cheeks, lips, etc.
- Issues of posture, coordination of breathing with swallowing
- Deglutition, pacing of intake, amount ingested, etc.
How does a clinician intervene?

- Explore if medical conditions coexist, underlie, or cause the feeding problem, weight gain, state regulation, etc.
- Consider possibility of gastroesophageal reflux, delay in gastric emptying, pyloric problems, etc.
Evaluation of the “total child”

- Sensory integration status of the baby
- Baby’s reactions to new environments and new people
- Reaction to noise/sound, visual stimuli, touch, position, movement in space
- Capacity to regulate states and focus on one activity or interaction
Evaluation of “total child”

- **Mood** of the infant
- Anxiety regarding eating?
- Learned to dread mealtime or the introduction of food? Level of stress and tension
- Is feeding too hard for the infant?
- How successful is the overall attempt to feed?
Evaluation of the “total child”

- Presence of other difficulties in the infant.
- Irritability, frequent or excessive crying
- Sleeping difficulties
- Anxiety and traumatic experiences
- Medical issues. Weight, height. What is the impact. Use of any medications?
Evaluation of interaction with caregiver

- During meal-time and at other times
- How does baby’s behavior impact the caregiver?
- How does caregiver behavior affect child?
- Is the child difficult to feed for anyone?
- How does feeding fit with the “transition to parenthood”?
Caregiving factors

“feeding agenda”
Beliefs, experience, skill, ability to understand child, make adaptations, flexibility
Level of frustration, attributions toward infant, relationship with food and feeding
Caregiver’s own experience as a child?
Caregiving factors

**HOW DOES FEEDING PROBLEM FIT WITH THE CULTURE**

- What, when, how “should” the baby eat?
- Why is the baby not eating? “fault”
- What is the reaction of spouse, grandmother and other people who give advice?
- How frustrated or “guilty” or worried do caregivers feel?
Evaluation of “ecological” factors

- Is there an adequate “feeding environment”?
- Level of stimulation in the home
- Is room made for eating?
- Could one eat in that environment?
- Interpersonal milieu….siblings, tension, marital issues, etc.
Interventions

- In all interventions therapeutic alliance with parents and with the baby
- Try to explain rationale for the problems and for the interventions suggested
- Diminish sense of failure, guilt, anger or frustration by understanding the child’s point of view or vulnerabilities.
The baby does not suck well.

- Takes too long to be breastfed or to ingest the content of a bottle
- Sucks weakly or gets tired after a short time, possibly falling asleep
- Seems to just bite on the nipple
- Takes long breaks and tends to fall asleep shortly after starting to feed.
II. Not suck well..

- The baby does not wake up to ask for food
- Infant tends to “sleep a lot”
- Takes very small amount of milk and then is satisfied, not continuing to eat
- Baby does not gain weight at the expected rate
Facilitate sucking

- Stimulate baby to continue sucking, maintain state of alertness
- Gentle vestibular stimulation vertical, horizontal, motion may maintain awake
- Touch infant, talk to baby, look in the eye, or try to wake up softly
- Uncover baby, temperature may assist in staying awake
Facilitate sucking

- Use different kinds of “nipples”, opening, size, shape, nipple shield
- Try different positions to feed
- Gentle tap on checks
- Wait for baby to recuperate and resume feeding.
- Help baby stay awake longer periods by interacting actively
Early sucking difficulties

- Feeding more frequently if necessary with smaller amounts at a time
- Waking up the baby to eat, e.g. during the night.
- Adapt caregiving to infant characteristics, e.g. more frequent or prolonged holding, positional preferences
- Promote better regulation of states, routine, buffering stimulation, calming strategies
The baby does not focus on eating.

- Child does not tolerate certain positions, e.g. recumbent on back.
- Child only eats (suck or ingest) for a brief period of time (1-2 minutes) and then loses interest.
- Baby refuses feedings as they are associated with negative experiences, e.g. crying, discomfort.
Lack of focus on eating

- The baby does not calm while eating, but becomes overstimulated.
- Baby squirms, moves around, makes noises and is more interested in the interaction than in feeding.
- Becomes too stimulated by the demands of feeding, becoming irritable or crying.
Lack of focus on eating

- Baby becomes distracted with slightest noise or with visual stimuli, light
- Baby prefers to eat only while falling asleep
- Baby only eats while asleep
- Infant does not ever sit for any length of time to eat
Lack of focus on eating

- Baby often is hypersensitive to touch, posture, textures, odors, sounds, visual stimulation
- Infant is often hyper-tonic and has difficulty organizing movement
- Difficulty in self-inhibition.
- Baby needs constant entertainment and changing scene to be content
Intervention

- Implement strategies that facilitate organization and focus
- Diminish the amount of sensory stimulation prior to feeding time
- Diminish input from television, radio, lively interaction with baby, movement in space
- Create calm atmosphere” baby may associate with eating
- Interaction in less sensory channels simultaneously
Intervention

- Promote relaxation or “decompression” prior to feeding
- Calm activity, massage, rocking, white noise, vibratory stimulation
- If overstimulated, break and later resume
- May need more frequent feedings
Intervention

- Earlier introduction of semisolid foods (more calories, not require sucking)
- Earlier use of alternatives to sucking, e.g., cups or initial chewing
- Earlier introduction of variety of food, attempting to find what baby might like
- Try different settings, positions, calming and coping strategies
Intervention

- May feed more times in day for shorter periods of time each
- Gradual tolerance of higher levels of stimulation and sensory input
- Respect for child’s vulnerabilities
- Gradual approximation and increase in challenges to the baby
The toddler only wants to eat milk or liquid foods

- Baby does not want any textured foods, only liquids, after six months of age.
- Baby only likes milk and is over-sensitive to textures, flavors, temperatures, gagging easily or spitting.
- Baby has more repertoire to refuse foods (close mouth, avert face, stick tongue out, arching back, etc.).
Assess other areas of functioning

- Motor functioning (tone, planning, fine and gross coordination)
- Sensory integration abilities or vulnerabilities
- Development of reciprocity, language, a relationship with caregivers
- Evaluate if hypersensitivity to odors, flavors, textures, etc.
Intervention

- Intervention with the total child, rather than just eating.
- Address any major developmental issues
- Gradual approximation to higher textures, conditioning rather than forcing.
- Start with earlier developmental stages, despite the actual chronological age of child and move forward in small steps
Intervention.

- Gradually introduce new textures and flavors
- May impregnate toys or hands of baby with new odors or flavors or textures to reduce sensory defensiveness and induce more acceptance of the new or feared
Intervention

- Promote maturation and diminish defensiveness in other areas
- Avoid excessive tension at mealtimes, child is often very anxious or sensitive
- Use of positive reinforcements, exposure to other children eating, adults eating and promote imitation
Intervention

“cognitive and behavioral” strategies

Use of visual representations to model to the child, e.g. in symbolic play situations

Use of “theatrical representations” e.g. with puppets or dolls to convey messages, based on infant learning preferences

Suggest to baby alternatives to his/her behavior.
Intervention

- Visual display with a person or with puppets of what the child does: e.g.
  - Fear of new foods,
  - Throwing food, spitting
  - Being scared of new foods
  - “empathize” with the child through visual display, e.g. “you are afraid” or “you are angry”
Intervention

- Propose new strategies of coping
- Gradual approximation to feared foods
- Change in behavioral repertoire, from active fighting during meal to gradual acceptance of new foods, textures, flavors, if possible given sensitivities
- “desensitization” strategy and positive reinforcement, indirectly and directly
The baby makes himself gag or vomit frequently

- Differentiate involuntary gagging (easy gag reflex) from voluntary gagging or vomiting.
- Eg. Merycism and rumination
- Obtain detailed accounts of what brings about the vomiting, and the reaction of the baby after vomiting
- If possible observe directly
Intervention for induced vomiting

If voluntary, gagging is part of the behavioral –coping- repertoire of the baby

E.g.

Need for stimulation and amusement
Need to entertain himself, an activity
A soothing –self soothing behavior , calming
May be a need to feel in control of self
Intervention

Behavioral analysis of the episodes of induced vomiting.

Intervention will depend on underlying or maintaining factors:

E.g. if maternal deprivation or boredom, promote more engagement with the baby
Intervention

If need for self-soothing:
- Diminish the amount of stress for the baby
- Assess if baby is exposed to difficult situations
- Teach alternative methods to infant of self soothing
- Promote parent soothing and regulating the baby
Intervention

- If need for control, observe if baby feels helpless and ineffective
- Give infant a sense of control, e.g. through play or interactions with the caregiver
- Promote cooperation and make defiance unnecessary, empathic caregiving
The baby eats non-edible items, I.e. Pica

Little known empirical information about its causation and phenomenology

Suspicion of diminished intake of iron, rule out iron deficiency

Traditional belief in the role of neglect from the mother, but this is questionable

Explore nature of parent infant relationship, usually the child is older (after 1.5 years)
Intervention

- Work with the child on the undesirability of eating certain objects, e.g. paper, dirt, cardboard

- Make visual representation of the behavior and mark negative emotion regarding the effects of the item on the body

- Explore with the child interest in the non-edible items through verbal exchanges
Intervention

Promote parental close monitoring of the behavior, and curtain the behavior in the child in an empathic way, e.g. protection.

Promote parental involvement with child in positive ways, rather than just focusing on the pica behaviors.
Intervention

- Suggest to child to abandon eating certain objects
- Set up positive (emotional) reinforcement for eating the right materials and not eating the wrong materials
- Work on psychodynamic issues that might maintain the behavior.