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Selective Eaters: A Different Type of Eating Disorder

By Carol Ann Brannon MS, RD, LD

“My child will only eat McDonald chicken nuggets, fries, Goldfish crackers, and macaroni and cheese from the blue box.” Does this sound familiar? Many of the children I work with have what I refer to as the “beige” diet. Is the “beige” diet a reflection of permissive parenting, strong-willed or spoiled children, or is there something else, perhaps biological or genetic, that is responsible for picky or problem eating? What is the difference between a picky eater and a problem feeder?

The most common myth about eating is that it comes naturally. In truth, eating is a complex process that involves all five senses, as well as the mechanics of chewing and swallowing. Food preferences and eating skills evolve and develop along a continuum throughout childhood. While we assume eating comes naturally, about 10 percent of all children exhibit some type of feeding problems ranging from mild to severe. The incidence of feeding problems is much higher, 40 to 70 percent, in children that were born prematurely and/or those with chronic medical conditions or developmental delays. Eating can be an overwhelming experience for many children, especially for special needs children and those with sensory integration challenges. Children with feeding problems may experience food jags, food neophobia, or sensory food aversions. A food jag occurs when a child will only eat a specific food, often a brand-specific, meal after meal until they eventually refuse this food and it may be “lost” from the diet for months, perhaps forever. Food neophobia refers to a fear of new foods characterized by strong reactions including gagging, vomiting, and/or

tantrums and overcome with anxiety. Food neophobia generally occurs about age 2 and declines around 5 years of age.

For families with a child or children with feeding problems, whether mild or severe, mealtimes are problematic, stressful, and can often feel like a battlefield. Parents are concerned about their child's nutritional status, weight, growth, and development. However, there is hope and help for picky and problem eaters.

During periods of developmental transitions it is common for a child to refuse foods they once ate with enjoyment and for their appetite to fluctuate. For example between the age of 18 months and 2 years a child is becoming increasingly independent, so it makes sense that they exert their independence in the area of food and eating. Children that are mildly picky eaters generally outgrow some of their selective eating habits as they transition to the next developmental stage.

In contrast, a problem feeder may have exhibited feeding difficulties since birth, particularly children born prematurely and/or with developmental delays of those with sensory integration disorder. One should not assume that permissive parenting is responsible, particularly as evidence is emerging suggesting more neuropsychological reasons for food aversions. Research indicates genetics may play a role in food aversions. Research has found that the number of taste buds in each square centimeter of the tongue varies from individual to individual. Children with a large number of taste buds may be more sensitive to food tastes and textures.

Problem eaters often require feeding therapy from a multidisciplinary team that includes professionals specially trained in feeding therapy. A multidisciplinary team generally includes a speech pathologist, occupational therapist, psychologist, and dietitian, as well as the entire family. Ideally, the child should receive an evaluation from a speech pathologist, an occupational therapist, a psychologist, a dietitian, a gastroenterologist, and an otolaryngologist.

The following are "red flags" for feeding therapy, as suggested by Dr. Kay Toomey, psychologist and developer of the SOS Approach to Feeding. If a toddler or child exhibits any of these signs may be a candidate for a feeding evaluation by a speech pathologist or occupational therapists specializing in feeding therapy.

***RED FLAGS®**

Is this child a candidate for referral?(Yes-if any of the following are present)

- Ongoing poor weight gain (rate re: percentiles falling) or weight loss
- Ongoing choking, gagging or coughing during meals and/or vomiting
- More than one incident of nasal reflux
- History of traumatic choking incident
- History of eating & breathing coordination problems, with ongoing respiratory issues
- Inability to transition to baby food purees by 10 months of age and table foods by one year
- Inability to transition from breast/bottle to a cup by 16 months of age
- Aversion or avoidance of all foods in specific texture or food group
- Food range of less than 20 foods, especially if foods are being dropped over time with no new foods replacing those lost
- An infant who cries and/or arches at most meals
- Parent repeatedly reports that the child is difficult for everyone to feed.
- Parental history of an eating disorder and a child not meeting weight goals.

* From the SOS Approach to Feeding Program.

Two well-recognized and evidence-based approaches to feeding therapy are the Sequential Oral Sensory (SOS) Approach to Feeding and Food Chaining™, which includes pre-chaining. Both of these approaches are sensory-based.

The SOS (Sequential Oral Sensory) feeding program is a non-invasive developmental approach to feeding. It focuses on increasing a child's comfort level exploring and learning about the different properties of foods, including texture, smell, taste and consistency. The SOS approach allows a child to interact with food in a playful, non-stressful way. This approach follows a hierarchy to feeding, beginning with the basic ability to tolerate food in the room, in front of him/her, touching and eventually tasting and eating foods. Parent education and involvement is an important part of this feeding approach.

Food chaining is designed for older toddlers and children. Therapists trained in Food Chaining™ begin by analyzing a child's current feeding habits to determine which tastes, textures, and temperatures are most acceptable to him/her. The foods that are currently tolerated are the foundation, while foods similar in taste, texture, and color are gradually introduced. Then as a new food is tolerated it becomes a part of foods offered to the child regularly. Diet expansion occurs very gradually, with only one or two foods introduced at a time to prevent a child from becoming overwhelmed.

For additional information about feeding therapy for sensory food aversions email Carol Ann Brannon MS, RD, LD at cabnutrition@bellsouth.net