

FEEDING BEHAVIORS – THE TIP OF THE ICEBERG

Society tends to label and classify most events in a two-dimensional “either-or” way. Multidimensional views are more complex and offer less certainty of cause and outcome. This is particularly true for children whose feeding difficulties are expressed through an aversion or resistance to eating. Although components of the feeding challenge may be described, the label of a “behavioral feeding problem” frequently is applied. For decades medicine classified illness as physical or psychological. Although many doctors still make this distinction, we now know that this is not accurate. There is such a total connection between the body and mind that every illness has both physical and psychological components. We know that our thoughts and emotions can strongly influence the medical course and outcome of a disease or illness that is reflected in the physical body. We also know that the presence of an illness or physical problem strongly influences our emotions and our responses to the underlying problem

Basically, every problem or illness is a mind-body problem. Every child who has difficulties with eating is responding along a mind-body continuum. Some children may begin their journey into feeding problems with physical, sensory, respiratory or gastrointestinal difficulties that make eating uncomfortable or unsafe. These children make choices to alter their eating patterns to take care of themselves. Their beliefs, emotions and experiences strongly influence the path that they will take in moving toward or away from eating. Not all children will respond in the same way to the same events. Thus, one child with severe reflux will refuse to eat when he has esophagitis but be content to eat small amounts when the esophagus has healed. Another child may perceive a much smaller amount of reflux as dangerous and painful and refuse to eat at all. Still another will perceive the sensations of food pressure in the esophagus as painful and eat only enough to take the edge off of his hunger, even though acid reflux is no longer present. One child with severe eating coordination problems related to cerebral palsy will struggle to eat and remain a functional oral-feeder. Another who has lesser coordination problems will tire and decide to stop eating before his nutritional needs are met. One child who consistently aspirates large amounts when swallowing will become very upset if she is not allowed to eat or drink; another child who aspirates a small amount intermittently will become highly cautious and limit the amount eaten.

Children who experience stress from external pressures to eat or the memory of earlier discomfort may become highly fearful about eating. These stresses can increase tension in the body, reducing physical coordination, increasing negative sensory perceptions, reducing gastric emptying, increasing reflux and limiting digestion. These are all direct physical difficulties that interact with the child’s mind and emotions. How can one say that a child simply has a “behavioral feeding problem”? What are the alternatives? We could begin by shifting our beliefs to consider that all children, (even the youngest babies) are doing the very best they know how to

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take care of themselves based on their beliefs and experiences. Children who choose not to eat are doing so for a reason and they perceive this as a way to take care of themselves and their needs to feel safe and be comfortable.

Every choice we make is a behavioral choice. I am, choosing the behavior of putting these thoughts into written form. Why? Because for my own reasons I perceive that this is in my best interest right now. It is an important way for me to organize my own thoughts and share them with others; and I like doing that. You are choosing the behavior of reading and responding to these words. Why?

You have your personal reasons, which represent your way of doing what you believe will support your best interests. There are physical and behavioral components for every child who is dealing with feeding challenges. If we are going to address these problems in an effective way, we need to incorporate approaches that acknowledge this and address the total picture. We need to help our children know that they have many alternatives and choices. Some children become very stuck in something that has worked for them in the past. Most adults can find similar examples of habitual, ineffective choices in their own lives. They need our help in discovering that they can be both safe and comfortable in developing a new relationship to food and mealtimes. We need to help children explore and discover easier and more coordinated

ways of eating and help them develop the oral-motor skills that may be missing or delayed because of lack of experience or difficulties in the sensorimotor areas. We need to explore stress-reduction strategies that can reduce fear and ease the impact of gastrointestinal discomfort. Trying to eliminate a behavioral choice that we don't like can actually increase the child's negative or aversive behaviors if the underlying reason for that choice of behavior is still present. We can support the child and encourage other choices as we help all children build their inner wanting to eat and the skills to do so. Professionals and parents who apply the label "behavioral feeding problem" to children limit their ability to see and honor the interplay between the mind and body components of the child's responses. Through a belief that behavioral choices should be modified and eliminated, the underlying reasons for these choices become ignored. Feeding therapy is directed at the tip of the iceberg—the symptoms or behaviors that the child manifests. This is similar to the tendency in conventional medicine to treat a disease with medications that suppress or deal strictly with the symptoms, rather than addressing the underlying causes of the condition.

An effective feeding therapy program addresses multidimensional problems with multidimensional approaches. It considers and honors the mind and body roots of the child's preference for eating and drinking in a limited way.

