

Feeding Difficulties in Infants and Young Children: Diagnostic Principles and Practical Tips

It is estimated that up to 25% of infants and young children develop some sort of feeding problem during their maturation including eating too little, restricted food preferences, delay in self-feeding, objectionable mealtime behaviours and unusual food habits. Furthermore, severe feeding problems that lead to poor weight gain occur in 1 to 2% of infants under the age of 1 year and 70% of these infants continue to have feeding problems four and six years later. “Feeding disorders also have been linked to later deficits in cognitive development, behavioural problems and eating disorders,” confirmed Dr. Irene Chatoor, Children’s National Medical Center, George Washington University, Washington, DC (*Child Adolesc Psychiatr Clin N Am* 2002;11:163-83).

Based on her own extensive work, Dr. Chatoor developed a classification system enumerating diagnostic criteria for feeding disorders in infants and children, focusing in on six specific feeding disorders.

Diagnostic criteria for feeding disorder of state regulation

- Infant has difficulty reaching and maintaining a state of calm alertness for feeding; is either too sleepy or too agitated or distressed to feed.
- Infant’s feeding difficulties start in the newborn period.
- Infant fails to gain adequate weight or shows weight loss.

Diagnostic criteria for feeding disorder of reciprocity (neglect)

- Infant shows lack of developmentally appropriate signs of social responsivity (visual engagement, smiling, babbling) during feeding.
- Infant shows significant growth deficiency.
- Growth deficiency and lack of relatedness are not solely caused by a physical disorder or pervasive developmental disorder.

Diagnostic criteria for feeding disorder associated with concurrent medical condition

- Child readily initiates feeding but over the course of feeding shows distress and refuses to continue feeding.
- Child has a concurrent medical condition that is believed to cause the distress.
- Medical management improves but does not fully alleviate the feeding problems.
- Child fails to gain adequate weight or may even lose weight.

Diagnostic criteria for sensory food aversions

- Child refuses to eat specific foods with specific tastes, textures, smells and appearances.
- Onset of the food refusal occurs during the introduction of a different type of food.
- Child eats better when offered preferred foods.
- Child must have specific nutritional deficiencies or oral motor delay or both.

Diagnostic criteria for infantile anorexia

- Child refuses to eat adequate amounts of food for at least one month.
- Onset of food refusal often occurs during the transition to spoon- and self-feeding, typically between 6 months and 3 years of age.
- Child does not communicate hunger and lacks interest in food but shows strong interest in exploration and interaction across caregiver contacts.
- Child shows significant growth deficiency.
- Refusal of food did not follow a traumatic event.
- Food refusal is not caused by an underlying medical illness.

Diagnostic criteria of post-traumatic feeding disorder

Food refusal follows a traumatic event or repeated traumatic insults to the oropharynx or GI tract (choking, severe vomiting, insertion of nasogastric or endotracheal tubes, suctioning) that trigger intense distress in the infant. Consistent refusal to eat manifests in one of the following ways:

- Child refuses to drink from the bottle but may accept food offered by spoon (may drink from the bottle when sleepy or asleep).
- Child refuses solid food but may accept the bottle.
- Child refuses all oral feedings. Reminders of the traumatic event cause distress, as manifested by one or more of the following:
 - Child may show anticipatory distress when positioned for feeding.
 - Child shows intense resistance when approached with bottle or food.
 - Child shows intense resistance to swallowing food placed in the mouth.
- The food refusal poses an acute or long-term threat to the child’s nutrition.