VOICES FROM THE FIELD -
Pediatric Feeding Disorders: The View from One Clinical Setting

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Service perspective

The CEECD reviews[1-5] on eating behaviour in young children, taken collectively, do an excellent job of covering the breadth of issues in this field. They confirm the progress that has been made over the last two decades in raising general awareness of the importance of eating behaviour in young children as a health concern and the progress that has been made in the biopsychosocial[6] framework that underpins current treatments when problems arise. They also highlight nicely the challenges that face the field. Benoit's caution that the field of feeding problems in infants and young children is still plagued by "inconsistent definitions, differing and essentially non-validated diagnostic and conceptual frameworks and inconsistent methodologies"[1] should be kept in mind by anyone reading the literature or working in this area.

This problem is particularly evident in discussions on the general incidence of feeding problems in which the data cited are typically 20 to 25 years old and the research was conducted with essentially non-validated and differing definitions. It is understandable that investigators do this because at the current time there is simply no better information. Canadian pediatric tertiary-care centres have responsibility for the health of the infants, children and adolescents living within their catchment area. Accepting that health-care dollars will continue to be scarce, if rational decisions are to be made in terms of the allocation of resources, then we need to have a better understanding of the numbers of children with specific types of feeding issues. For example, Black[2] in her review focuses on the development of healthy eating styles for children in the general population in order to prevent the myriad of health issues that arise from obesity. The overall cost for society of the "obesity epidemic" is projected to be massive,[7, 8] and thus an ounce of prevention may save considerable money in the long term for provincial health-care budgets. At the same time, Piazza[4] presents data suggesting that successful intensive behavioural intervention for children to wean them from tube feeds results in a net cost savings. While in an ideal world both initiatives would be funded, the reality on the front lines is that choices on where to allocate scarce resources are having to be made. Having more accurate information on the incidence and natural course of feeding issues, both in the medically vulnerable and in the general, currently healthy populations, would be helpful in guiding the development of services.

In terms of promoting healthy eating behaviour in the general population, Black[2] presents a constructive overview, calling for research into why children have selective food preferences (the "picky" eaters). A recent longitudinal study[9] found that children's food preferences varied considerably across food groups, with children liking more than 75% of breads, pastas and desserts, but less than half of the vegetables or meat alternatives. Food preferences were formed early and remained surprisingly stable, with little change observed between the ages of two and eight. Importantly, children enjoyed a wider variety of vegetables as infants than during the toddler or pre-school years.[10] This has focused attention on the toddler years and the transition to independent eating of regular table foods. We clearly need to know more about this specific transition period so that effective interventions can be designed for the general public. Burklow's[3] comments in this regard that "feeding programs need to collaborate with community programs" and "these primary intervention efforts need to be empirically tested" are quite convincing.

In terms of the severe end of the spectrum (children who are medically vulnerable and require prolonged tube feeding), Ramsay[5] suggests that a key research question is "how effective are behavioural interventions for severe problematic feeding behaviours in medically ill infants?" I would refine that question, since numerous individual studies, as summarized in the CEECD review by Piazza[4] and more systematically by Kerwin,[6] have demonstrated that behavioural interventions are effective for severe feeding problems. Behavioural interventions, however, are not effective for all children. Research needs to look at the factors associated with unsuccessful treatment — is it because there are underlying physical issues involving the basic appetite mechanism of these children, as Ramsay's paper suggests, or are there aspects of behavioural treatment that make transfer of behavioural strategies into the home setting difficult for some families? Burklow's paper[3] presents a series of questions in this regard, such as the impact of behavioural interventions on relationships within the family unit, that now need to be explored.

Establishing intensive behavioural interventions for severe feeding problems has been and will remain problematic for Canadian institutions for several reasons. First, there is the problem of "economy of scale." Piazza[4] does not provide the specific details behind her cost estimates for the intensive treatment of feeding problems; however, the figures would inevitably be dependent on questions of scale (i.e. how many children can the program treat during a year and are those children "available" for treatment). Intensive feeding programs based in the United States, like the one at the Kennedy Krieger Institute in Baltimore, literally draw pediatric patients from all over the U.S. and the world and thus have no problem maintaining a patient pool that makes intensive feeding programs economically viable. Given the population difference between the U.S. and Canada, it is unlikely that the incidence of severe feeding problems would be high enough for many parts of Canada to make the establishment of such intensive feeding programs feasible. Therefore, Burklow's recommendation that "for children who require intensive feeding treatment, additional models of treatment need to be explored"[3] is particularly important for Canadian service delivery.

Secondly, most Canadian university graduates of clinical training programs in psychology are well schooled in the cognitive-behavioural framework, but the emphasis is generally on the "cognitive" part, with graduates having relatively little experience

applying the behavioural techniques of shaping and contingent consequences with the developmentally young. With the increasing recognition of applied behavioural analysis as the treatment of choice in the early intervention for autistic spectrum disorders, this may eventually expand the training models in some programs, but it will still be years before this would have an impact on service delivery.

On a closing note, in their CEECD reviews Benoit and Ramsay both stress the need for the continued development of interdisciplinary feeding teams and the training of experts in the field of pediatric feeding disorders as important policy priorities. If we are ever to overcome the problem of "inconsistent definitions, differing and essentially non-validated diagnostic and conceptual frameworks and inconsistent methodologies," however, then policy must also include a mechanism to bring Canadian professionals together to discuss and resolve these inconsistencies and differences; to facilitate multi-centre studies that can answer key research questions; and to form advocacy strategies so that this important area of child development can receive the necessary government and public support.

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