Supporting Children who have a Restricted Diet Resource Pack

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MIDAS
Meadowfield Inclusion Development and Support

Contents Page

INTRODUCTION

This resource pack has been developed to support settings, schools and parents where they have children who present with restricted diets. This is likely, but not exclusively to be the case for children with an Autism Spectrum Disorder.

For most of us eating is a pleasurable experience: it relieves our hunger, comforts us, excites our senses and heightens our anticipation. It is so much more than a functional skill. We are taught that eating is a social time, a family time, a time to have discussions and share our thoughts and plans. Mealtimes are used to promote social rules and manners around eating which will vary from culture to culture and from family to family.

For those of us charged with nurturing and educating infants and young children, eating can also be accompanied by a range of emotions including: our desire to nourish a child, to keep them healthy and growing strong, teaching them how to use cutlery or reinforcing our perception of good table manners.

When difficulties occur, a range of emotions can surface including: anxiety about health and weight gain, frustration when the child refuses to eat something they previously did, dismay that their eating habits are not what we expected or a sense of failure that we don't seem able to change things.

The aim of this resource pack is to set out the developmental processes of taste acquisition and eating skills and then explore some of the reasons these processes can be interrupted.

By understanding typical development, we can identify when difficulties occur and are better placed to identify and implement effective strategies.

This resource pack does not replace the need for expert specialist advice which should always be sought where a child's eating difficulties are causing:

- significant weight loss
- failure to achieve expected weight
- faltering growth
- significant nutritional deficiency

The Development of Taste

Some newborn babies may have an inherited predisposition to certain tastes and early taste preferences may indicate later adult preferences. Exposure to tastes affects preferences over the first 12 months of life and taste develops as follows:

- **From birth to 3 months** there is significant acceptance of sweet taste
- **From 3 to 6 months** the development of salty taste acceptance occurs
- **By 6 months** sweet tastes remain dominant followed by acceptance of salty tastes and both of these are more preferred than bitter and sour
- **By 12 months** sweet and salty tastes are equally accepted with sour, bitter & umami tastes being less tolerated

Developmental Changes in the Acceptance of the Five Basic Tastes in the First Year of Life (Schwartz.C/Issanchou.S/Nicklous.S). British Journal of Nutrition Vol 102, issue 9.

From birth, infants can partially regulate their food intake and energy needs.

At roughly 6 weeks of age they can meet their growth and energy needs by taking only the number of calories they require.

This regulation can change from day to day to week by week in young children.

Fomon 1976.

In the first 12 months of life infants primarily recognise food by taste & texture and then by how it looks. The following four developmental processes have been identified:

- Children learn about foods through their taste, texture and appearance
- They see others eat the food and develop an understanding of food choices which they begin to imitate
- They make associations related to foods and nutrition
- They begin recognising foods in categories

Manon Mura Paroche, SJ Caton, Carolus MJL Vereijken, Hugo Weenen, Carmel Houston-Price. How Infants & Young Children Learn about Food. A Systematic Review. Front.Pscychol.8:1046 doi:10.3389/fpscyg.2017.01046.

The Mechanics of Eating

From 6 to 12 months, oral motor skills develop through having the experience of food textures in the mouth. The tongue movements for moving food around are learned and chewing skills develop.

As infants move from puree to bite & dissolve foods a process of desensitising the inside of their mouth occurs. The following table shows typical development of eating skills:

Age	Food texture	Developing Skill
5-6 months	Puree	Beginning to suck and bite. Up & down chewing motion. The gag reflex starts to decline.
7-8 months	Thicker puree Mashable food	Side to side tongue movements.
9-12 months	Mashable food	Moves food around in the mouth.
12-18 months	Bite & dissolve Bite & melt Bite & soft chew Bite & splinter Bite & lumpy	Bites food Eats chopped food At 18 months can eat chunky cut food and is beginning to refuse foods
24-36 months		The child has developed likes and dislikes and begins to refuse some foods. May be a picky eater.

The Neophobic Response

The neophobic response is a developmental stage where the rejection of new or unknown food occurs. This can include food that is marked (a speckled banana) and familiar food that is presented differently.

It is a phase that typically begins at around 20 months and decreases with age and is thought to be linked to an intrinsic instinct to avoid harmful foods.

Birch. L.L. Development of food preferences. Annual Review of Nutrition. 1999.

Research has found that if infants have one exposure to a new food then consumption of that food will be double the next time it is offered. However, by the age of 4 multiple exposures to the new food are needed to achieve increased consumption.

Birch, Gunder, Grimm Thomas & Laing 1998 /Birch, Mcphee, Shoba, Pirok & Steinberg 1987.

Alongside the neophobic response research has shown that children show a **disgust and contamination response** from around 20 months. This can present as a refusal to touch food that has touched a disliked food and/or a gag response.

Brown.S. & Harris.G.2012

Avoidant & Restrictive Food Intake Disorder

DSM 5 Child Mental Health Classification. 2013

ARFID is a developmental eating disorder linked to the neophobic stage and sensory hypersensitivity.

Children with ARFID do not move out of the neophobic stage and continue to have a contamination and disgust response to new foods.

Children with ARFID will be slow to move forward with eating new foods and will be brand specific in contrast to those with an acquired eating disorder e.g. anorexia who will move on quickly and will not be brand specific.

ARFID is often associated with but not exclusive to those with an Autism Spectrum Disorder.

www.arfidawarenessuk.org

PICA

PICA is the persistent eating of non-nutritive substances and is a feeding and eating disorder listed in the DSM 5.

PICA is Latin for Magpie.

It is potentially life threatening with the possibility of ingesting toxic substances or materials, perforation or aspiration.

If you have a child with PICA this must be risk assessed, with a plan put in place including the management of medical emergencies.

Eating Difficulties & ASD

Both neuro typical children and those with a developmental impairment can have eating difficulties, however it can often be observed in children with autism. This can be due to a need for sameness, a focus on detail, social interaction impairment, sensory sensitivities and anxiety.

This may present as:

• Eating fewer than 20 foods • Refusing all food from one or more food groups • Losing weight or not growing • Gaining weight • Displaying PICA	• Missing school • Constipation • Tooth decay • Coughing or choking when eating • Chest infections

Other factors that may contribute to restrictive eating:

• Pain and/or illness • Constipation • Reflux • Medication	• Tooth ache and mouth ulcers • Physical and developmental delay • Poor muscle tone

Strategies for Supporting Children with Eating Difficulties

1. Information

- Gather information from all settings and monitor the child's eating. It is important to know in detail what the child will eat, when and how and this may vary in different environments
- See appendix 1 for an example of an eating plan

2. Food Categories

- Work on food categories to develop the child's understanding that one food can take different forms. For example, bananas can be long, short, speckled, straight or curved, but they are all bananas.
- Make picture collections of different foods.
- Give choices – e.g. if the child eats apples offer a red and a green apple.
- Narrate your own choices 'I am going to have the small apple'.
- Role play – A teddy bear picnic- fill a packed lunch box with for example carrots (whole, sliced, sticks). Then play picnics choosing different carrots to feed to the bears.

3. Communication

- Establish the child's communication in relation to food, eating and mealtimes. If they are non-verbal, do they use symbols or signing? What do you do to let the child know it is time to eat?
- Agree between home and setting what vocabulary will be used – lunch, dinner, tea, supper?
- Think developmentally – does the child refuse food by closing their mouth, turning their head away, hold food in their mouth, spit food out?

4. Anxiety

- Think in terms of a child's safe foods rather than healthy/unhealthy food.
- Reduce anxiety by allowing the child to have their safe foods in their familiar routines.
- Use calming sensory activities before and during mealtimes.
- Use distraction – to reduce hyper-vigilance around food, this may increase intake of food. For example; link eating with a story/song on a tablet device, however this is only done if the child is eating and stops if they leave and should not be used with children who over eat.

5. Reduce Sensory Sensitivities

- Remember the hierarchy of food textures and work from where the child is. Bite and dissolve foods are a stepping stone from smooth to textured food.
- Make environmental changes where necessary. Reduce noise and movement and consider how to minimise distractions through seating position and wearing of ear defenders.

6. Introducing New Food

- Remember the child is likely to be stuck in the neophobic stage.
- Make the new food available to touch, smell, lick and put in the mouth without putting any pressure on the child.
- Role play with the new food, get the pots and pans out and pretend to cook.
- Place new food on a separate plate and not on the plate with their safe food.
- If the child spits out a new food do not react. Remember the disgust and contamination response.

7. Special Interests

- Does the child have a particular favourite character? If so use it and put their food on a Thomas the Tank Engine or Peppa Pig dish or plate.
- Personalised place mats with their favourite character/s.
- Decorate the snack/lunch area with their interests.
- Allow the child to have a special item with them but only if they are eating, remove it if they are not eating.

8. General

- Avoid using a child's preferred food to reward them for eating a non-preferred food. The child should be able to have their safe food unconditionally at the appropriate times.
- Try removing food packaging to address brand specific issues.
- Create regular and consistent times for eating to regulate and create hunger.
- Model the eating behaviour you are introducing.
- Encourage exercise, this will help with over eating and will also be a good way to reduce stress.

Autism.org
Dr E.Shea. Birmingham Food Refusal Service

A Final Note…

Support for eating difficulties is available from a variety of sources. Referrals can be made to:

- Community Paediatricians where there are concerns regarding developmental conditions
- Speech Therapy where chewing and swallowing is a concern
- Occupational Therapy where sensory sensitivities and/or oral motor skills are of concern