

Independent Feeding Answers to Some Common Ques

INDEPENDENT FEEDING: Answers to Some Common Questions



This is the first of a three-part series that will examine various elements involved in the self-feeding process, and how occupational therapists can help children improve self-feeding skills.

By Rhoda P. Erhardt

As an OT who has specialized in hand function, I am concerned about eye-hand coordination, skill development and self-help tasks such as feeding. Like many OTs, I frequently encounter feeding problems in children with developmental disabilities, especially cerebral palsy. A primary goal expressed by parents, teachers, therapists, and, of course, the children, is to achieve independent eating--finger feeding, utensil use, and eventually meal preparation.

The problems described may be mild, moderate, or severe, and involve not only the mouth but also the hands. In fact, for a good understanding of the feeding process, the OT's knowledge base needs to include both normal and atypical development of the entire body, and exactly how all those system components enhance or interfere with self-feeding. A future article in this series will present a comprehensive systems approach to the transition process from finger feeding to utensil use that I developed during consultation services I provided to the Gerber Products Company.

When I teach workshops throughout the United States and overseas, I hear many of the same questions over and over, and many of them are related to self-feeding:

Q. What is the best way to help a child transition from bottle to cup?

It really depends on the age of the child, his or her intake of other food, and developmental readiness. For example, parents whose child's nutritional needs are being met with solid food have an easier time withholding the bottle and offering the cup, at least during the day at first. The child who still needs to suck, for self-regulation (emotional needs) or to improve lip musculature (motor needs), can benefit from learning to use a straw. The MagMag® system works well for some children, because it has a series of bottle tops, beginning with a nipple, then a soft spout, a straw, and finally a training top. It is available from Omron, (800) 231-3434.

Q. Should parents let the child play with feeding utensils (spoon, cup, straws) to help them normalize sensory input, explore new shapes, and practice hand-to-mouth patterns, in preparation for self-feeding?

Parents often give their babies spoons to play with during dependent feeding, to prevent them from grabbing the parent's spoon. However, as their baby begins to develop self-feeding skills, the parent withdraws within a relatively short time. It is usually not socially age-appropriate for children with developmental delays to use feeding utensils as toys. A better alternative to give the child would be a variety of oral-motor toys such as horns (blowing), harmonicas (vibration), tubing necklaces (chewing), etc. Many of those toys are available from PDP Products (651) 439-8865 and New Visions (804) 361-2285.

Q. How can we help a child who wants to self-feed with a spoon but still has active reflexes such as the grasp reflex and/or avoiding responses?

Although the grasp reflex prevents a child from opening the hand to independently pick up a utensil, it actually assists a child in maintaining grasp once the utensil is placed in the child's hand. The avoiding response, however, may be responsible for unintended release. A universal cuff is a simple and useful solution. It can easily be made from Velcro® straps. (see Fig. 1)

Q. Why do some children who have advanced to self-feeding with utensils, refuse foods that have mixed consistencies, e.g. soup with vegetables or cereal with milk?

This problem has two components: sensory and motor. If sensory processing is inadequate, these children cannot discriminate easily between the solids and liquids, and may not know what they are and where they are in the mouth. If motor control is deficient, they may have trouble dissociating one part of the oral musculature from the other parts, such as jaw, tongue, and lips, to manipulate the food efficiently within the mouth for chewing and preparation for swallowing. We can help them with the transition from smooth to mixed textures by combining foods that are very similar, then less similar, and finally very different.

Q. Why do children have an easier time controlling the cup when it is almost full instead of containing only a little liquid?

A full cup requires minimal neck extension, thus a shorter and more comfortable range of movement to be coordinated with finely graded wrist/hand movements and lip/tongue movements during drinking.

Q. What can parents do when their child is frustrated by a new task, such as using a fork, but won't accept help?

First we need to analyze the problem, and determine which components need adaptation. Is the child positioned with proximal stability (head, trunk, pelvis) for distal mobility (arm, hand, fingers)? Is the problem with accuracy of shoulder, forearm, and/or wrist movement for correct hand placement? Does the child have an efficient grasp? Is the hand-to-mouth pattern accurate? Can the lips remove food from the utensil?

The task itself can be adapted to make success easier, with special utensil handles, a Dycem® base for the plate if the child does not hold it with the other hand, and food that is easy to stab. Some children will allow a parent to guide the handle of the utensil, rather than use the hand-over-hand method. Also, activities with clay can provide practice.

Q. Why do some children get stuck in that normal negative two-year-old stage, like refusing new foods, for example, and what can we do to help them expand the variety of textures they will accept?

The negative stage of eating is a common problem in children with sensory issues and in those whose parents have been very worried about nutritional intake. These children will accept certain familiar foods only, and have a very limited repertoire of favorites. The primary problem of sensory defensiveness must be addressed first, before the secondary behavioral problem. A future article in this series will present a sensorimotor approach to feeding problems in children with failure to thrive.

Q. How can we work toward more independence in the older child who still needs external control by the caregiver to use a cup without spilling?

The caregiver could alternate jaw control with hand control, so the child can develop skill in one, instead of having to cope with both at the same time.

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