APPENDIX E

ASSESSMENT OF FEEDING / GROWTH PROBLEMS

Satter EM. Appendix E, Assessment of Feeding/Growth Problems. *Your Child's Weight: Helping Without Harming*. Madison, WI: Kelcy Press; 2005

Any feeding advice that goes beyond basic good parenting, positive feeding, and supporting normal growth and development is *treatment*. Doing treatment absolutely mandates doing a careful and detailed assessment to provide a clear understanding of the underpinnings and antecedents of a child's eating problems and causes of weight divergence. I teach that assessment in detail in the "Feeding with Love and Good Sense VISIONS" workshop. Here, I will review that teaching briefly.

It is normal for children to eat well, grow predictably, and love and accept their bodies. When they do not, the organizing question is, "What is interfering with this child's normal ability?" Answering that question requires careful examination of the history and context of the child and the problem. For the younger child, the crosscutting task of the assessment is to explore factors that have contributed and continue to contribute to parents' inability to enact Ellyn Satter's Division of Responsibility in Feeding. For the older child and adolescent, it is to identify the child's capabilities with respect to eating and activity—or lack of them—and to explore the antecedents and underpinnings of

those capabilities.

I took a preventive stance in writing *Your Child's Weight*—supporting parents in their task of responsibly and reasonably raising their children to get the body that is right for them. However, *Your Child's Weight* can be used as a *remedial* as well as a *preventive* book by evaluating a given child and situation in the light of optimum developmental and feeding recommendations and identifying and correcting gaps and errors in feeding or parenting. At times, parents can go through the remedial process on their own. Erica's parents, who were introduced in chapter 2, "Feed and Parent in the Best Way," took a clear look at themselves, identified their errors in feeding, and corrected them.

However, in many cases a problem is too established or too complicated for parents to understand and resolve it on their own, even aided by a self-help book such as this one. Typically, an established feeding problem has been dealt with in a piecemeal fashion. Parents have tried repeatedly to solve the problem, without success. They have been given much advice, often contradictory, generally poorly founded. Even in professional practice, feeding advice is often based on feeding lore rather than evidence-based feeding practice.

While all the clinical cases I discuss in *Your Child's Weight* are based on the careful assessment plan I outline here, in three stories the assessment process is particularly apparent. Review the stories of Haley in chapter 6, "Optimize Feeding: Your School-Age Child," and Melissa and Marcus in chapter 10, "Understand Your Child's Growth."

What Causes Established Feeding Problems?

Whatever the presenting complaint, I know at the outset that a major focus of the intervention will be restoring the stage-appropriate division of responsibility in feeding. However, before going ahead with a feeding intervention, it is important to identify the factors that have precipitated and may continue to exacerbate the distortion in feeding dynamics. Parents have reasons for feeding their child the way they do. To let go of their old ways, they need the security of knowing that the problem has been examined thoroughly; all the previous, partial, and counterproductive explanations reviewed and either ruled out or taken into account; and a treatment plan developed that incorporates all considerations. Doing a complete and systematic evaluation is essential to allow the parent to set aside unhelpful explanations and tactics and fully commit to the assessment and treatment plan.

Options for resolving puzzling and seemingly insoluble problems will emerge among the details generated by the assessment. Sally

Provence, a widely known pediatrician who worked in the Yale Child Study Center, encouraged physicians to "embrace complexity" rather than settle for simplistic answers. However, to gather the details, the health professional has to be able to tolerate the anxiety of *not knowing* until the interpretation and solution become apparent.

What could be behind an eating problem? The core of the problem may have been poor feeding practice, often based on unwise advice. The child's own characteristics may have contributed: Her normally large size may have been misinterpreted as overweight, restrained feeding instituted, and the consequently food-preoccupied child overate and gained too much weight. The child's continual hunger and food-preoccupation may have permeated her relationships with self and others. As a result, she has strongly learned to misuse food for emotional reasons.

The core of the problem might have been medical and physical. A child with an oral-motor limitation or medical problem was seen as being incapable with respect to eating or medically fragile. Her frightened parents responded naturally—and counterproductively—by pressuring her to eat. The medical or oral-motor problem has since been resolved, but the distorted feeding interactions remain. The distortions have been exacerbated at each stage in development, as parents attempted to compensate for the faulty learning of the stage before.

The root cause of the problem might have been nutrition or food selection. The food might not have been appropriate for the child's oral-motor development at a given stage, or the food was so unappealing, low in fat, or low in calories that the child wasn't interested in eating or couldn't eat enough to grow well.

The problem may have grown out of the parents' agenda for their child's size and shape or their own relationship with food. Chronically dieting parents may have imposed their own food-restriction tactics on their child. Restraining and disinhibiting parents may have pulled their child along with their own cycles of going on and then falling off from diets.

What the Parents Must Provide

To ensure success with the assessment, it is essential to consider both *process* and *content*. Relative to *process*, parents must be clearly informed about the nature and process of the assessment, the reasons for the detailed examination, what they need to provide, and what it will cost. Then they must be supported in choosing to go ahead or not to go ahead at each stage of the assessment. However, parents must be

told that if they choose *not* to have the assessment, then they must settle for the general kind of advice about feeding and parenting that I give in my books and teaching materials. It's neither possible nor ethical to give specific advice about particular problems without understanding those problems in detail.

Relative to *content*, issues that impinge on feeding are to be carefully examined: medical, developmental, nutritional, psychosocial, and feeding dynamics. I explain each in detail below.

To do the assessment, I need complete medical records from birth, including the narrative. This applies to adolescents as well as to infants and to every age in between. I need a 7-day food-intake record with enough detail to allow analysis; videotapes of three or four typical family meals with all the principal people in place and visible on the tapes; and information releases to the people who know the child well, for instance, the physician, a preschool or home room teacher or school counselor. If there are family meals, I ask for videotapes, no matter the age of the child.

I analyze all the materials and then set up two or three interviews with the parents and child. The first interview is with both parents and child. The parents discuss their concerns with the child and give her an opportunity to respond. Then I see the child alone, both to get the child's view of the problem and to get a sense of the child's emotional and social functioning. I spend a second interview with the parents alone, getting more detail on the child's developmental history and the nature of family functioning.

Content of the Assessment

Each part of the assessment has a role to play with respect to getting to the bottom of the child's eating and growth problem.

- **Medical:** In addition to reviewing clinical records from birth, I depend on the child's physician to have done a recent and careful physical examination, with parents' concerns in mind, to assure us that any medical problems that may contribute to the difficulty have been identified. I also talk with the physician about the parents' concerns and get his or her perspective on the child and family.

  The narrative from birth in the clinical records often gives information about the child and family that parents have forgotten. It also notes medical interventions and advice that may have had an impact on feeding. Haley's parents did not remember

being told their 10-month-old daughter was obese and denied restricting her food intake from that time. However, from then on Haley's weight became unstable.

I replot growth data from the clinical record. Growth data may have been incorrectly plotted in the hurry of the clinical setting, and plotting it correctly will change the parents' perception of the child's ability to grow well.

Once the growth chart has been clearly delineated, the task is to tease apart the story the growth chart tells.

- **Developmental:** The growth chart often reflects the degree to which a child has achieved the tasks of each developmental stage. Using the growth chart as a basis for discussion, I ask the parent, "What happened here—and here?" A sudden shift up or down at a given stage generally signals disruption in developmental achievement of that stage. For instance, Haley's rapid weight gain as a toddler provided a clue that she had not fully achieved autonomy. When she got into school, rather than being able to join in comfortably with her peer group, she continued to struggle to keep herself the center of attention. Asking specific, stage-related questions helps bring forth detailed developmental information, although rigid or chaotic families have trouble providing details. The narrative from the medical record is helpful in filling in gaps.

  Because the developmental part of the assessment tends to deal with parenting in general, activity fits in this segment. Managing television use, encouraging and giving opportunities for developmentally appropriate active play, expecting the child to entertain himself, and being able to tolerate reasonable commotion are all parenting issues that can be assessed in a general discussion.
- **Nutrition and food selection:** Based on the interview with the parents and analysis and evaluation of a 7-day food intake record, the nutrition/food selection part of the assessment looks for past or present food- or nutrition-related clues to the child's eating/growth problem. This part of the assessment determines the source of the child's nutritional support (for instance, eating or grazing voluntarily, naso-gastric tube, force-feeding), assesses the child's energy intake and nutritional status, determines whether the food is developmentally appropriate, and looks for evidence of restrained feeding (unusually narrow day-to-day calorie variation or food servings in round numbers) or restraint and disinhibition (unusually wide day-to-day calorie variation).

  Previous, counterproductive nutrition or food selection advice

and tactics can contribute to a child's eating and growth problem. Frequently parents have limited the finicky child's menu to food she readily accepts or limited the "overweight" child's menu to drab, unexciting, very low-fat food. While this part of the assessment gives clues for ways parents can improve menu planning, its primary benefit is in ruling out food selection as the basis for the problem and the intervention. Despite the struggles around feeding and the child's erratic eating, most children do well nutritionally. The finicky child's nutrient intake is generally at or near adequate levels; the large child's energy intake is generally well within or even at the low end of normal ranges.

- **Psychosocial:** The psychosocial assessment has to do with the *context* of feeding: the child's overall social and emotional environment as provided by the parent. Since I most often teach this model to health professionals, the goal is to identify dysfunction that is pronounced enough to interfere with eating management and require a referral to social services or to a mental health provider. I encourage my trainees to look for "red flags," such as evidence of abuse or neglect, overly involved or controlling parents, or those who are not involved enough and even laissez-faire. Parents may have rigid agendas, lack empathy for their child, or have little sensitivity for how their own behavior contributes to the problem. Both parents' and children's emotional responses may be out of proportion to the situation at hand. The whole family may overreact to moderate issues or underreact to serious ones.

  Some family dysfunction may be temporary, precipitated by crisis. For instance, when a child has first been diagnosed with a severe illness, otherwise functional parents may become enmeshed and overprotective at the one extreme or may distance themselves emotionally from the child at the other. They may become more rigid and controlling than usual or go to the other extreme and become chaotic.
- **Feeding/eating dynamics:** Whatever the precipitating or exacerbating causes of the eating and growth problem, the feeding relationship will be affected. Parents and children will be crossing the lines of the division of responsibility in feeding. For the younger child, accurate assessment requires *observation* of the feeding interaction; parent report is not accurate or sufficient. Such observation is also helpful for the older child, but in the absence of family meals, it is necessary to make do with extrapolating from in-office interactions. Parents who are controlling or disengaged in office

interactions are likely to be the same with respect to feeding and parenting overall.

Since parents' eating attitudes and behaviors impinge directly on the child's feeding problem, I assess parents' eating competence as well, using my own questionnaire, "About Your Eating." The questionnaire assesses eating attitudes, food regulation, and food-acceptance behaviors and the ability to manage food context: feeding themselves (and their family) regularly. I use the same questionnaire with teenagers, although I assume scores on food context will be low.

Detecting and explaining feeding distortions draws on information gleaned from the rest of the evaluation. Child temperamental characteristics such as negativity, irritability, or exaggerated caution may call out overactive or intrusive feeding behaviors. Medical issues, particularly life-threatening ones, are virtually guaranteed to distort feeding dynamics as frightened parents try to ensure their child's nutritional well-being or even survival. Parents' own learning about nutrition, food selection, or eating may be faulty. An exceptionally large or small child may challenge parents' ability to be trusting with respect to feeding.

Once the assessment and the treatment plan is in place, parents can be told in detail what caused the problems with their child's eating and growth. Growing out of that detailed problem identification, they can be provided with a detailed treatment plan. That treatment plan and its enactment will be reviewed in appendix F, "Treatment of Feeding/Growth Problems."