Feeding problems in children with DD/ASDs: From useful assessment to effective treatment

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Overview

- Fdg prbs in ASDs vs DD/TDC
  - Are there special concerns? Y/N
  - Issues related to Autism Tx and Fdg
- Food selectivity in ASDs
  - Is it a problem?
  - When it is what do (can) you do?
  - Exposure!
  - Vomiting
- Refusal; Expulsion; Vomiting
- And your cases
Kids who didn’t eat vegetables

- **Matt**
  - 4
  - Moderately selective
  - Ate chicken nuggets and other breaded proteins, no fruit/veg

- **Dave**
  - 3.5
  - Mildly selective
  - Ate chicken nuggets, some bread, turkey, some fruit, no veg

Txs tried and outcomes

- **Matt**
  - Introduced new brands of old items
  - Reinforced eating with TV access
  - Ate peas, corn, green peppers, carrots within 2 months

- **Dave**
  - Introduced new brands/items
  - Reinforced eating with preferred videos
  - Restricted access to preferred videos, blocked disruptive behavior
  - 9 months before first veggie eaten
Follow-up

- **Matt (mild dev. delays)**
  - TV access moved to end of meal
  - Started eating salad (modeled by mom)
  - Also ate a variety of fruits (req. apple)

- **Dave (Autism)**
  - 3 months after 1st veg (was eating 3) got sick refused veg when better
  - 2 months later veg was recovered
  - Video access signaled on token board
  - Eats 3 fruits with prompting

Kids who didn’t eat

- **Robert (TDC)**
  - 4 (on initial evaluation)
  - Total food refusal
  - Severe GI involvement, OM deficits

- **Bob (CWA)**
  - 3.5 (on intake)
  - Total food refusal
  - History of eating (bottles), gagging/vomiting w/ ear infections
Txs tried and outcomes

- Robert (following medical TX)
  - Introduced rewards for accepting ES
  - Gradually introduced pureed foods
  - Required escape prevention (3 times; 1 x per caregiver)
  - Taught OM skills (lateral placement; modeling)
  - Volume limited intake (no more than 4 oz)

- Bob (following ear tube placement)
  - Introduced formula on spoon
  - Gradually introduced pureed foods
  - Introduced rewards for swallowing
  - OM skills emerged; regular foods in 6 mo.

Why is feeding of particular concern to parents of children with ASD/DD?

- Awareness of health risk with ASDs/DD
  - Related conditions
  - Problems in typical development
- Resistance to change (Kanner, 1943)
  - Fdg skills develop as each child ages
- Transitions (Stevenson & Allare, 1991)
  - Liquid → Solid
  - Pureed → Textured
- Typical child prblms during transition
Do children with autism have aberrant eating habits?

- Ahearn et al. (2001): 50%+ selective
  >25% overly selective (1 food grp)
  70% for starches
- Remove gluten from diet?
- Parents report more Fdg prb
  - Schreck, Williams, and Smith (2004)
- Narrower range, family diet → child diet
  - Schreck and Williams (2006)
- Children w/ASDs may eat more than TDCs
  - (Raiten & Massaro, 1986)

Treating ASDs via Diet?

- Diet and behavior
  - Feingold was wrong
  - Hoover & Milich (1994); words over sugar
- GFCF diet
  - Anecdotal report (e.g., Cade et al., 2000)
  - Elder et al. (2006)
  - Data to determine effects
- Ketogenic diet
  - Evangeliou et al. (2003); intractable seizures
Treating the gut?

- Gut Txs of ASD → No change in autism
- Diets as Tx → For true allergy/intolerance

- Vitamins as Tx
  - 1995 NIMH Subcommittee
  - Lawson et al. (2007); Overuse & prostate cancer
- Secretin (e.g., Roberts et al., 2001)

What is a feeding problem?

- Most critical function of eating
  - Caloric intake
  - Growth and weight gain
What is a feeding problem?

- Refusal → Selectivity
  - Ahearn (2001)
- The role of early history
  - TFR = good reason to not want to eat
  - Selectivity = decline in diet or static?
- Food and texture selectivity
  - Early identification = hi prob. Success
  - Texture selectivity/caloric intake/oral motor skills
- Variables associated w/ difficult fdg problems
  - GI symptoms → Pediatric Gastroenterologist
  - OM → SPL

Questions
Assessment of eating

- Functional assessment?
- Evaluate physical status
  - Weight/growth/output
  - GI functioning
- Evaluate intake through observation
  - Food logs (Ahearn, 2001)
  - In vivo assessment (Munk & Repp, 1994)
  - Expert multi-disciplinary assessment (e.g., Kedesdy & Budd, 1998)

Direct Assessment – Food Log

- Diet history
  - Sample of presentation and intake
  - Across day
  - No changes to mealtime, etc.

- Observation in natural environment
  - Assessing behavioral dynamics
  - Attention/Escape/Esc + access to SR+
Diet History - Summary

- Categorizing eating patterns
  - Overly & moderately selective
  - Mildly selective
  - Food refusal (chronic vs acute)

- Problems of limited exposure
  - Other limitations
Outcome of observation

- Rule out physiological factors
- Identify skill deficits
  Decide whether they are important
- ID problems in the eating environment
- Establish goals

Selective eating

- Categories (Ahearn et al., 2001)
  - Overly/severely
  - Moderately
  - Mildly
  - Texture selective
- Develops why? (Piazza et al., 2003)
  - Escape from NP
  - Attention (?)
  - Tangibles (Escape to other food)
Consequences & Presentation

- Timing of food presentation
  Grazing/Access to food outside of meals
- Motivational operations
- Exposure to foods

Birch & Marlin (1982)

Observing selective eating

- Limited exposure = restricted diet
  - Child refusal shapes parent behavior
  - Parent behavior fosters selectivity
- Diet records (Ahearn, 2001)
  - 128 records, autism/selective eaters
  - <20% prob. NP item (<50% acc)
Selective Eating

- Develops when? (Carruth et al., 2004)
  - As many as 50% of all toddlers
  - Selectivity increases w/ age
  - Typically meet nutritional requirements
- Transient? (Carruth & Skinner, 2000)
  - Severe traced to early eating history (Marchi & Cohen, 1990)

Structuring mealtimes

- Existing structure to meals
  - Meal as routine
- Altering structure
  - Eating environment
  - Timing of access to food
  - Discrete trial format
  - Which items are presented
  - How to present them
  - Routines with items/plate
- From structure to exposure
What to do first

- Diet record summary
- Select foods for exposure
  - Half of foods should be preferred
  - 1-3 target (new) items for each group
  - At least 1 item from each food group
  - Don’t choose bitter or smelly foods

Procedures

- Exposure program
  - 18 sessions (1 block)
  - Target item presented 6 times per block
  - Self-feeder presentation
  - No differential consequences
  - About 30 minutes before meal
Procedures

- Meals (session)
  - 2 accepted + 2 target items
  - 5 presentations of each item
  - Order of presentation quasi-randomized
  - Single-item on plate
  - "(Child’s name), take a bite"
  - 5-10 s to consume
  - Refusal = neutral removal
  - 30 s ITI

Picky Eaters

- Mike
  - 4, ASD
  - Moderately selective
  - Preferred starch, limited pro, no fruit/veg

- Chris
  - 2.5, ASD
  - Mildly selective
  - Preferred starch, limited pro/veg/fruit
  - Gagging/vomiting
Results & Discussion

- Exposure = improved intake
  - All consumed target items
  - Results generalized to meals
- Selectivity shaped
  - Consistent presentation of variety
  - Exposure sessions like DTT
- Limited to mild feeding problems
  - Novel foods in assessment

Questions?
Quick Review of Treatments

- Medical intervention
- Altering the feeding environment
  - Mealtime structure and food exposure
  - Simultaneous presentation
  - Food blending + fading
- Arranging new consequences
  - Pos. reinf. (Kedesdy et al., ‘98)
  - Escape prevention (Ahearn et al., 1996)
- Teaching
  - Texture fading (Shore et al., 1998)
  - Task analysis (Luiselli, 1993)

Positive Reinforcement

- Access to preferred foods?? (Riordan et al., 1980)
- Access to activities/attention (Kerwin et al., 1995)

- Using highly preferred items
  - Motivated to earn/limited access at other times
  - Assessment (Fisher et al., 1992)
  - Reinforce each accepted bite immediately
Example - Larry

- 4 year old boy diagnosed with autism
- Eating at meals good but variety decreasing
- Accepted a variety of starches/proteins
  - Limited intake of fruits/vegetables
- Goal - Increase acceptance of Fruit/Veg
  - Starting point - Fruit

Feeding Sessions

- Baseline - 15 presentations of fruit
  - 5 each
- Most preferred item was video
  - 30 seconds of “Barney” for acceptance
- Data recorded on Accepts/Expel
- 15 total bites presented during treatment
- Target Item
  - Beginning of session
  - 3 bites added after eating criteria met
Simultaneous presentation

- Sequential presentation (as SR+)
  - (Riordan et al., 1980; 1984)

- Simultaneous presentation
  - (Kern & Marder, 1996)

- Sim. Presentation w/out EP (SR+)
  - (Piazza et al., 2002)
Simultaneous presentation w/out SR+

- Fred ate no vegetables
  (Ahearn et al., 2001)
- Ate a variety of starches, proteins, condiments
- PS preference assessment
  - Ketchup, BBQ sauce, salad dressing
- Multiple baseline design across V
  - Withdrawal to BL btw condiments

Simultaneous presentation w/out SR+

- 5 consecutive presentations of each
- BL – no differential consequences
- SP – food + 5cc of condiment
- Each condiment introduced in MB
Simultaneous presentation and fading

- Transfer of stimulus control

- Texture fading
  - (Shore et al., 1998)

- Probes and “errorless”

- Blending preferred and nonpreferred
  - Low concentration of NP
Simultaneous presentation and fading

- Phil - selective and ate few proteins
- Consumed variety of fruits
  - Inconsistent acceptance
- Targeted fruits and chicken
  - 5 nonconsecutive bites of each item
- Differential reinforcement
  - Acceptance resulted in activity access
  - Refusal resulted in neutral removal
Simultaneous presentation and fading

- Accepted age-appropriate texture
- Decreased texture of banana to puree
  - About ¾ of spoonful
- Mixed in a small amount of chicken
- Gradually increased amount of NP
  - Concomitant decrease in banana
- Increased texture of chicken back to small bite sized pieces

![Graph showing percentage of bites accepted](image)
Escape prevention

- Consumption of food required to end meal
- Professional supervision necessary

- Nonremoval of the spoon
  - (Ahearn et al., 1996; Cooper et al., 1995)
- Physical guidance
  - (Ahearn et al., 1996; Riordan et al., 1980)

Example - Paul

- 4 year old boy diagnosed with autism
- Overly selective
- Quit eating solid food during illness
- Previously ate grilled cheese and pancakes
- Accepted no food for 4 weeks
- Goal - Increase acceptance
  - Starting point – Foods previously consumed
Physical Guidance

- Parent selected intervention
- Conducted at school
- Two therapists for each meal
- SR+ food acceptance – HP items
- Refusal – prompt at jaw
- 4 total prompts prior to Ind. ACC
  - New food at 7th meal
  - 12 foods IA in 39 meals
  - 3 months from no solids to feeding himself at home without physical prompting

Figure 1.
Comparing NR and PG

- Both very effective
  - Acceptance may be more rapid with PG
- Side effects
  - In NR Meals longer - more time = more side effects
  - PG sometimes suppresses other aberrant behavior
- Treatment acceptability
Gagging and Vomiting

- Why do children gag?
  - Novel textures (Texture sensitivity?)
  - Lack of oral competence (elicitation)
  - Illness
  - To avoid consuming NP foods

- What can be done?
  - Do not provide undue attention/escape
  - Teach oral skills/repeated exposure
  - Access to preferred liquids
  - Escape prevention???

Example - Matt

- 5 year old boy diagnosed with autism
- Eating at meals good but gagged/vomited 4-5x/week
- Accepted a variety of starches/proteins
  - Limited intake of fruits/vegetables
- Goal – Decrease vomiting
  - Starting point – Assessing cause
Exposure

- During assessment
  - Gags on veggies (mostly greens)
  - Gags during first 1-2 presentations

- Exposed to foods that led to gags
  - Consecutive presentations of NP/P
  - No attention (lined garbage can)
  - Later presented novel foods/scents
Expulsion

- Lacking OM skills
  - Texture fading → lumps
  - Lateral placement (on molars)
  - Modeling
- Escape prevention
  - Re-presentation (standard in PG/NR)
  - Flipped spoon/nuk brush (Piazza and colleagues, 2011)
Closing comments

- Prevention of the development of selective feeding for children with autism
- Early intervention
- Availability and accessibility of resources

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Gut theory of autism

- Measles insults the gut causing bowel dysfunction which then results in regression
  - Wakefield et al. (1998) – RETRACTED
  - GMC hearing
  - Gut-theory of autism: Empirical evidence against
    - MMR (e.g., Madsen et al., 2002)
    - MMR/Bowel (Taylor et al., 2002)
  - GI/Autism (Black, Kaye, & Jick, 2002)
  - Mayo clinic (Ibrahim et al., 2009)
  - Buie et al. (2010)
D’Souza, Fombonne et al. (2006)

- Presence of measles in gut/blood/tissue
  - Detected by polymerase chain reaction assays
- Used same techniques as others
- Larger N
- Used improved contaminant control
- No measles virus found in control or ASDs

Stephen Bustin/Nicholas Chadwick OAP

Number of deaths last year = over 200,000
Millions maimed – blind, deaf, scarring
US – prevaccine 3-4 M cases/yr; 1 in 250 died; 50k hospital; 1000 permanently disabled
Post 1997 usually fewer than 100/yr, until 2008+
Eating patterns of children w/ ASD

- 30 children diagnosed w/ Autism/PDD-NOS (Ahearn et al., 2001)
  Ranging in age from 3y 9m to 14y 2m
- Survey of eating habits
- 6 meals for each child
  - 24 presentations per session
  - 4 food groups
  - 3 items per group
  - 2 textures

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<th>VEGE</th>
<th>PROT</th>
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- All accepts pureed except 3 bites of banana

- Graphs showing the number of bites accepted by each participant.
Questions?