Suid-Afrikaanse Tydskrif vir Geneeskunde : South African Medical Journal

Kaapstad, 18 Februarie 1961 Deel 35 No 7 Volume 35 Cape Town, 18 February 1961

Special Article

FEEDING PROBLEMS OF YOUNG CHILDREN OF PRE-SCHOOL AGE

I. MIRVISH, M.B., CH.B. (CAPE TOWN), M.R.C.P. (EDIN.)

Paediatrician, Red Cross War Memorial Children's Hospital and Groote Schuur Hospital, Cape Town

The prime biological necessity for eating naturally implies that any disturbance of this function in a child will be looked upon with anxiety by the parents. Hence, children of pre-school age are often brought to the doctor with the complaint that 'my child won't eat'. This does not necessarily mean that the child is suffering from anorexia, i.e. lack of appetite, as the term is generally used in adult practice. It is the general experience that 'my child won't eat' refers to a number of feeding disorders, varying widely in their causation, mode of onset, and pattern of behaviour. Thus, on being asked to qualify the main complaint, parents may state that the child 'won't eat what is good for him', or that he is finicky or fussy or capricious about his food, or that he will only eat if his mother tells him stories. Other departures from normal feeding behaviour, as observed by parents, will be indicated by the following remarks:

'He won't eat a thing.'
'He won't touch his food.' 'He hardly touches his food.'
'He's maddeningly slow about his eating.'
'I have to coax him to eat.' 'I have to force him to eat.'
'He won't eat his vegetables.' 'He only wants to eat sweets.'
'I'm afraid he will get ill.' 'I'm afraid he's sickening for something.'

These 'cries from the heart' will be familiar to all practitioners. Listened to carefully, without interruption, they provide, like all medical histories, valuable diagnostic clues. They also afford a much needed opportunity for a harassed mother to unburden herself of her pent-up feelings.

Common Features

Though varying in aetiology, feeding disorders tend to have certain features in common. In the first place evidence of ill-health (except in the small group to be described later), is rarely found on physical examination. The nutritional state, too, will be found to be far better than one would have anticipated from the harrowing tales of 'not eating' described by the parents. The third and most important common feature is that the *anxiety* exhibited by the parents and family circle appears to be out of proportion to the child's apparent well-being and good health. It is often a degree of anxiety one would normally expect when a child is seriously ill. The anxiety may be revealed by the intense preoccupation with the child's feeding habits. Other symptoms and other topics may be referred to, but sooner or later the discussion will revert to the central theme.

The Significance of Anxiety

It is important to investigate the reasons for excessive parental anxiety so that parents can be reassured and their fears resolved, by a clear insight into their problems.

The anxiety is an expression of one or several *fears* which may be overt, i.e. directly expressed, or discovered only by more detailed questioning. In the preface to *Of Human Servitude*, Spinoza says: 'For where a man is prey to his emotions, he is not his own master, but lies at the mercy of fortune, so much so that he is often compelled, while seeing that which is better for him to follow that which is worse'.

There is the obvious fear that the disturbance is a manifestation of ill health, that it will leave the child deformed or retarded, that it will inhibit his growth, that he will become a chronic invalid, or worst of all, that he will die of it. There is the deep anxiety and hurt felt by a mother that by refusing to eat the food she has prepared for him, the child is rejecting the love she bears for him.

Anxiety is particularly common in the mothers who have a feeling of guilt about their children. The child might not have been wanted, or its arrival might have interfered with the mother's professional or other interests. The mother compensates for this feeling of guilt by excessive indulgence. Any illness or upset shown by the child may be interpreted as a form of punishment meted out to the mother for past misdemeanours, real or imaginary.

Parental anxiety is likely to be marked where the child is particularly precious. There is the only child, the only boy in a family of girls, the first grandchild in a large family, the child born after many years of marriage; there is the child born to middle-aged parents, long after a previous birth, and the first child born after one or several tragedies. These children are candidates for behaviour problems of all kinds, and particularly of feeding problems.

The child's reaction to abnormal parental anxiety is familiar to all conversant with common behaviour problems. Should he at any time imagine or suspect that he is not receiving his quota of parental love and attention, there is a sure and certain way of improving his situation — he has merely to become a 'feeding problem'. He may do this by creating a disturbance at table by refusing food altogether, by merely nibbling at a previously favoured food, or by eating only under conditions which will disrupt the household routine. He may use his 'not eating' as a direct form of blackmail, promising to eat only after certain demands have been exacted. If there is parental or family disharmony, so much the better; if one will scold, another will rush to his defence, but he knows that when the tumult and the shouting dies, he will still emerge as the central figure on the stage.

SOME COMMON FEEDING PROBLEMS

It is not easy to classify the feeding problems of young children. A broad classification would include: those associated with acute and chronic ill-health, dietary faults due to ignorance about the fundamental nutritional requirements of children and about the preparation of food, and psychological disturbances. It should be remembered, too, that several feeding problems can, and do, frequently exist together in the same child.

1. *Feeding Disorders Associated with Acute or Chronic Ill-health*

Only a small proportion of children who 'won't eat' belong to this group and the cause is usually self-evident. The common example is of the child who goes off his food at the onset of an acute infection. Here true anorexia is present, but it is rarely the most prominent or only symptom, being seen in its true perspective as the diagnosis becomes established. In chronic ill-health, it may take a little longer to realize that the anorexia is merely one symptom of a particular disorder. When pica or perverted appetite is a feature of the feeding problem in this age group, one ought to look for evidence of iron-deficiency anaemia. Lanzkowsky[1] has shown that correction of the anaemia in these children produced a rapid and dramatic cure of the pica, usually within 1 - 2 weeks of the beginning of the therapy.

2. *Faulty Notions about the Feeding or Nutritional Requirements of Children*

In my own experience many of the children who 'won't eat' belong to this category. Becoming a parent does not necessarily bring with it a comprehensive knowledge of child-care or of nutrition. In addition, there are the obvious limitations imposed by socio-economic factors such as poverty, overcrowding, the lack of proper facilities for the cooking and preparation of food, and the necessity for the mother to go out to work.

Within those limitations, one of the commonest problems in this group concerns the child who 'won't eat what's good for him'. This, of course, means what mother father, aunt, or person-in-charge considers is good for him. With the best intentions in the world, what is thought to be good for him may not be consistent with accepted nutritional standards, or with the child's own concept of what is good for him. (The philosophy of authority is closely bound up with the "what's good for him" outlook, but only the nutritional aspect of the subject will be referred to here.)

What a mother considers good for her child will, of course, vary enormously. Generally speaking, where finances allow, the average mother will choose a reasonable diet for her children. Difficulty arises when the child has marked likes and dislikes which do not run parallel to parental concepts. The mother may be convinced about the efficacy of a food or foods for which the child has no liking. Or, conversely (and perversely), the child may show a preference for foods which the mother does not consider good for him. Differences may also arise about the quantity and quality of the food, i.e. the amount of food eaten, and the way it is prepared and served.

The best way to assess the situation in the 'won't eat what's good for him' group (apart from living in his home for a while), is to investigate *in detail* the child's daily feeding routine and to make a careful study of his eating habits, particularly of his likes and dislikes. Many studies have shown that this type of child, if given a free choice, would select a good well-balanced diet. On the other hand, if the child's choice of food conflicts with that of the parents, disaster threatens.

It is a tragi-comic situation that is encountered in conversation with these parents: 'Does he like meat?' 'He can eat it twice a day'. 'Does he like fish?' 'Yes'. 'Eggs?' 'Yes'. 'Fruit?' 'Yes'. Then there is a pause, and there follows the inevitable, 'But doctor, he won't eat his vegetables', or 'he won't drink up all his milk' as the tragic denouement.

The resultant psychological explosion takes two forms: (*a*) Parental anxiety because the child bilks at food considered essential for his health, and (*b*) disturbance of the child's natural good appetite by the tense situation produced by quarrelling, bullying, blackmail, and resentment. 'You can only have a second helping or enjoy your favourite pudding if you . . . ', sums up the situation. If the child rebels, as so often happens, mealtimes become battles involving not only mother and child, but often other members of the family as well. The inevitable result is that mealtimes become associated with unpleasantness and a general state of tension.

A good illustration of the 'won't eat what's good for you' mentality applies to the common dietary fault of attaching too much value to *boiled vegetables* as an essential item in the diet of young children. Now, while most children like well-prepared salads of appetizing appearance, few are fond of boiled vegetables, particularly when, as so often happens, they are badly prepared, i.e. mixed indiscriminately together to give the child the 'maximum amount of goodness and vitamins'. But the poignant cry of 'he won't eat his vegetables', tends to make this not-so-essential item the most precious commodity in human diet.

Milk is also a food about which misunderstanding often prevails. (This statement applies to economically well-off children and not to those who are kwashiorkor prone.) Assuming that a well-balanced diet is accepted, 1 pint of milk a day is ample for children of the pre-school age, but many mothers expect their children to drink twice that amount. If a child is not fond of milk, or if he objects to boiled milk, which his mother insists on, a feeding problem is invited.

OTHER DIETARY FAULTS

Other food fads and fancies may be revealed by careful interrogation. Apart from the well-known 'diets' which enjoy the fashion of the moment, there are many mistaken notions about food which will be familiar to practitioners of experience. As examples of common fallacies in this part of the country, there is a popular notion that eggs are harmful to small boys if given more than once or twice a week; the harm is not related to cholesterol but to their supposed aphrodisiac effect. In the Cape Flats, folklore maintains that meat 'brings worms', and numbers of young children may be deprived of meat for this reason.

Henson,[2] in a fascinating article on false medical beliefs,

discusses some of the false beliefs concerning food encountered in the course of his work at the Health Centre, Grassy Park. Among these are: that too much meat and/or bread causes worms, that squashes contain valuable foodstuffs, and that lemons dry up the blood. Guavas are said to be unhealthy because they cause appendicitis, and in winter time tomatoes are dangerous to give to children. Popular belief also avers that *maasbankers* (a kind of fish) are not fit for decent people to eat, though Henson points out that these fish are cheap, rich in vitamin A, and delicately flavoured when cooked fresh. The various 'diets' which are so popular have already been referred to. Therapeutic dieting by adult members of the family, as recommended for obesity, peptic ulcer, hypertension, and diabetes, may also be disturbing to the child by setting a bad example in eating habits. Social customs and national dietetic habits can create difficulties, e.g. when parents maintain a conservative attachment to traditional dishes, which are not always acceptable to the young.

A common dietary fault concerns the *preparation* of food. Good food, well prepared and pleasantly served, is not only the privilege of grown-ups, but parents regularly fail to understand this. A small child is often expected to eat a 'mush' which would nauseate the delicate palates of his elders.

PSYCHOLOGICAL ASPECTS OF THE 'CHILD WHO WON'T EAT'-PROBLEM

Some of the psychological factors of this problem have already been mentioned. They include the element of parental anxiety and its effects, conflict between parent and child in the feeding situation, and conflict between parents — expressed either in general marital disagreement, or in respect of the child's feeding habits. The issue becomes further complicated when, as often happens, other members of the family become involved. *In general, any situation which causes tension in the home may be the cause of poor or disturbed eating habits.* Common speech is full of allusions to the action of the emotions upon the appetite or digestion — 'Too upset to eat', 'too frightened to eat', 'too tense to eat', 'too excited to eat'. On the other hand everyone agrees that relaxation and absence of tension, as exemplified by an atmosphere of love and good fellowship, is conducive to healthy appetite and the pleasurable enjoyment of food. 'Now good digestion wait on appetite and health on both' says Shakespeare. 'Better a handful of herbs where love is', says *Proverbs*, 'than a stalled ox and hatred therewith'.

Among the causes of tension not yet referred to, is the situation produced by *sibling rivalry*. This is usually precipitated by the arrival of a new baby. The child who has reigned supreme, perhaps for several years, suddenly has to share with a hated rival. Refusing to eat, eating only if bribed or coaxed, eating only if fed by mother — all these are attention-drawing devices which rarely fail.

Rigid discipline is another important cause of tension. The withdrawal of a favourite food unless or until the less favoured one is accepted, has been mentioned. The *slow eater* too, is often labelled a 'won't eater' by a demanding parent, though basically there is nothing wrong with his appetite. Another form of feeding discipline concerns a *too rigid schedule*. The child, with hardly any warning and at a given signal, is expected to drop his toys or stop his play, run and wash his hands, and present himself at table. There he must act the Little Lord Fauntleroy, complete with correct table-manners, manipulating knife and fork with dexterity, and consuming all the food set before him — pleasantly and efficiently. This, of course, is an exaggerated picture, but modifications are common, and tension is the result.

One way of demonstrating the effect of tension, is to enquire into the child's feeding behaviour when there is a *minimum* of tension present. This situation fortunately, does occur at times, such as when the family is on holiday, or enjoying a picnic together at the sea-side or in the country. There is plenty of fun and adventure with the thrill of cooking and preparing a meal in the open at a picnic. Discipline is relaxed, table manners are not *de rigueur* and there is no argument about what should or should not be eaten. At such times little Tommy, the 'won't eater', cannot get enough, often making a pig of himself. At a birthday party or a visit to friends, the impossible Tommy will behave with the utmost decorum, and his appetite and behaviour at table would surprise and gladden the hearts of anxious mothers, grannies, and aunts — if they could see without being seen or heard!

In assessing the significance of the psychological element in these problems, the opinion of the family doctor, by virtue of his intimate knowledge of the child and the family background, is of particular value. His experience should be useful in preventing a too-hasty label of 'behaviour problem' before the other causes previously mentioned have been studied and investigated.

CONCLUSION

Treatment of the 'child who won't eat' involves far more than mere physical appraisal of the child. It necessitates a knowledge of the food requirements of children of various ages and an understanding of the normal and abnormal feeding behaviour of children at the various stages of development. In addition, the treatment of these children requires an appreciation of how emotional problems may affect the appetite and eating habits of young children of the pre-school age. Finally, it should be remembered that the child who is a problem-eater is likely to have problem parents who need to be treated with sympathy and given guidance and reassurance.

SUMMARY

In the clinical approach to the problem of feeding disorders in young children, the following regime is suggested:

1. Look for evidence of ill-health.
2. Investigate in detail the child's feeding schedule throughout the day, noting *when* he eats, *what* he eats, *how* he eats, and whether he feeds himself. Enquire into the child's likes and dislikes with regard to food, and whether these accord with parental notions. If possible, be present at a meal or two. This will give some idea of how the meals are prepared and served, and will give an indication of the family relationships and discipline at table. Find out, or observe if possible, whether the child is a 'slow eater'.
3. Look for emotional disturbances causing tension, e.g. sibling rivalry, parental disharmony, excessive disci-

pline. Learn to recognize and appraise the anxiety and tension associated with the 'precious child'.

4. The true nature of the problem, after it has been unfolded, should be explained to the parents. Physical disturbances should be treated. If the feeding programme has been wrong, it should be pointed out to the parents and corrected. Other faulty approaches in child management, if present, should also be attended to. Lastly, seek the cause or causes of the parent's anxiety and allay these by frank discussion and reassurance.

REFERENCES

1. Lanzkowsky, P. (1959): Arch. Dis. Childh., **34**, 140.
2. Henson, J. (1950): S. Afr. Med. J., **24**, 203.