

Considerations Before Trying to Change Your Child's Diet

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When Leo Kanner, a physician at the Johns Hopkins Hospital, published the first description of children with autism in 1943, he reported that they not only had problems with language and social skills, but that they also had limited dietary intake. Since that time, numerous studies have confirmed his findings that children with autism spectrum disorders (ASD) often have limited diets. The studies report on children with ASD whose intakes are limited not only by food type but also by temperature, texture, and even color. In this article, I share six things I have learned from the scientific and clinical literature on eating behavior in people. The goal of this article is not to describe interventions or treatments for food selectivity, but to provide some general information that may be helpful as you consider your child's diet and how it might be changed.



Food preferences are learned. Infants are not born liking carrots or candy. We all learn to like new foods by tasting them. This process often requires repeated taste exposures. Infants are the quickest learners and develop preferences for new foods in less than five tastes. Adults are the slowest learners and often require more than 20 tastes. School-aged children fall somewhere in the middle and require 10 to 15 tastes to develop a food preference. While interventions for increasing diet variety can take many forms, all successful ones will involve having children repeatedly taste foods over a period of time. Tasting must involve eating the food. Research shows that looking at, smelling, touching, or playing with food *without* eating the food does not help in the development of food preferences. While many interventions involve smelling or touching, they must also involve eating at some point. Developing a preference for a new food is a matter of repetition. The more a person tastes a particular new food, the more likely he or she will be to develop a preference for that food. The need for repeated exposure means that interventions have to be conducted over time. Research has also shown that children with ASD can learn food preferences, and that the number of taste exposures required is no greater than for children without ASD.



Taste is independent of dose. This means that the size of the portion does not matter. It is important to recognize that eating a tiny piece of a green bean is equivalent to eating a plateful of green beans when it comes to taste. The child does not need to eat entire servings or portions, or even multiple pieces, of a novel food at a sitting. This makes tasting much easier for the child. The critical factor is the repeated tasting of the novel food over the course of time. I often tell parents that it is better to taste one tiny bite of a new food on twenty different occasions than to taste twenty bites of food on a single occasion. When introducing a new food, offering bites the size of a pea, or even of a grain of rice, can make tasting easier and less scary for the child.



Gagging can go away. It is common for children to gag, and even vomit, when new foods are presented. In most cases, the gagging is not the result of delays in oral motor skills but rather a reaction to the food due to sensory sensitivity or anxiety. To address gagging, I often use three techniques. The first is reducing the size of the bite to the point at which it is barely visible, and then increasing the size only in the absence of gagging. The second is to instruct or incentivize the child to chew. Since gagging and chewing are incompatible responses in humans, children who are chewing cannot gag. The third strategy is distraction. When children gag, they usually continue to gag until the food is swallowed or expelled, or until they vomit. Gagging can thus be considered a chain of behaviors. As soon as the child tastes the food, I immediately offer enthusiastic praise and redirect to a preferred object or activity. The goal is to distract the child from gagging and to interrupt the chain of behaviors. With continued exposure to the food, the child will become familiar with the sensory properties of the food, such as its taste, texture, and temperature, and the gagging will go away.



Consider a child's biology. Before implementing an intervention designed to increase your child's diet, it is important to ascertain if there are biological factors which could impact eating. Constipation, gastroesophageal reflux, and diarrhea are all common in children with ASD and can affect eating. For example, children with constipation may experience abdominal pain or discomfort, which could affect the desire to eat. If you suspect a medical issue, it is important to discuss the matter with your child's healthcare provider.



Recognize that hunger is important. Hunger is the signal that your body needs food, and it is related to food choice. When a person is hungry, individual taste preferences become less important than food availability. A child who is hungry is more likely to taste a new food than a child who is not hungry. Children who continuously drink or graze throughout the day may not experience hunger, which means that there will be one less source of motivation for tasting new foods. I am not suggesting the use of hunger as the only component in an intervention, but rather that consideration be given to the importance of hunger. It is okay for children to experience some hunger. If they never experience hunger, it will be hard for them to learn how to self-regulate their intake of food.

Vitamins are essential. While advertisements for some products commonly use the phrase, "essential vitamins and minerals," this is not just a marketing ploy. In fact, there are vitamins and minerals that are essential to life, and their absence results in serious health issues and even death. Selective eating, also known as "picky eating" or "faddy eating," is often portrayed in the popular media as a benign problem which eventually resolves with age. It is true that younger children often have limited diets, and diet variety does improve with age for many children, both with and without ASD. There are, however, children whose diets are limited to the point of being nutritionally insufficient. Numerous studies have found children with ASD whose diets lack in one or more vitamins and minerals. In the clinical literature, persons with ASD are over-represented in studies describing persons who exhibit deficiencies in specific nutrients, such as vitamin C, vitamin A, or iron. While eating a balanced diet consisting of foods from all food groups is an excellent goal for all children, it is often a long-term goal. For some children, it may be more important over the short term to address immediate diet inadequacy with multivitamins or some form of vitamin supplementation.

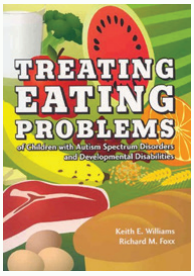
I hope that parents and caregivers find this article helpful. I have tried to share information that is either not provided to parents or that is not readily accessible. One of the hallmarks of ASD is resistance to change. By encouraging your child to learn to eat a range of healthy foods, you are directly addressing this common characteristic. In the end, this may make his or her life just a little easier by allowing greater flexibility.





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