Commentary: Beyond Feeding Problems: The Challenge of Meeting Dietary Recommendations in the Treatment of Chronic Diseases in Pediatrics

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Diet is a critical component in the treatment/management of many pediatric illnesses such as cystic fibrosis (CF) and diabetes. Diet during childhood is also hypothesized to influence the development of disorders that occur in adulthood such as cardiovascular disease and osteoporosis. As demonstrated in the current review of feeding/eating disorders, psychological interventions may be effective in changing dietary patterns in children. To date, these interventions have typically been applied to feeding disorders that result in undernourishment. However, the assessment and intervention techniques may have wide application to other chronic illnesses of childhood and in the modification of eating patterns established in childhood that are associated with adult diseases. The challenge for pediatric psychologists is to extend the application of psychological assessment and interventions beyond feeding disorders to these other dietary challenges.

The literature on CF and feeding behavior has demonstrated the challenge of meeting dietary requirements of chronic conditions. In a recent analysis of parent-child dinner interactions, children with CF and their parents did not differ in the types of behaviors or the proportion of these behaviors exhibited over time at the meal. However, families with children with CF spent an average of 6 minutes more at the dinner meal and demonstrated twice the frequency of both adaptive and maladaptive behaviors. Longer mealtimes and increased behavior potentially account for the increased stress parents report in response to meals and dietary requirements. Other than CF and feeding disorders, little attention has been paid to behavioral factors that contribute to dietary adherence in chronic illness populations, despite the importance of diet to optimal health care.

Another area of intervention is in young children (ages 4–8) newly diagnosed with diabetes. These children typically experience significant changes in their diet. More important than the types of food, however, may be the rigidity in meal timing and the need to eat soon after insulin administration. Clinicians and parents alike anecdotally report ongoing struggles around mealtime including cajoling, coaxing, and making alternative meals in order to ensure adequate food consumption following insulin. However, the prevalence and duration (number of months or years) of such struggles have never been assessed and thus the need for intervention is unclear. Given the anecdotal reports and the efficacy of behavioral interventions with similar feeding difficulties, this would appear to be an appropriate avenue for future assessment and possible intervention.

Behavioral researchers have long been involved in modifying dietary habits that are hypothesized...
to influence the incidence of cardiovascular disease in adulthood. A second area of growing concern is the prevention or delay of osteoporosis through calcium intake. Children with CF, juvenile rheumatoid arthritis (JRA), and ulcerative colitis (UC) are at risk for osteoporosis in adolescence and in early adulthood secondary to disease factors. All children receiving corticosteroids are at risk because of the effects of steroids on bone density. Research is needed to examine the effects of calcium consumption on bone density in these populations. However, before this can be accomplished, children's calcium intake must be increased to optimal levels. Research on dietary calcium has demonstrated that children's and adolescents' typical consumption of 800 mg is far below recommended levels of 1,500 mg/calcium per day. Modifying dietary habits in children has proven to be more difficult than simply instructing parents to serve more calcium-rich foods. The research on nutrition and other diseases (CF) indicates that knowledge and typical parenting strategies are not sufficient to change eating behaviors. Thus, equipping parents with child management strategies may be necessary to modify dietary intake of calcium. Pediatric psychologists can be instrumental in examining these behavioral and environmental factors that contribute and interfere with optimal dietary calcium intake. In summary, a number of pediatric conditions require dietary treatment for optimal health. To date, few studies have targeted dietary recommendations separately from other aspects of the treatment regimen. Clearly, eating behaviors can present unique challenges to children and their parents and may be enhanced by specifically designed interventions. Pediatric psychologists may be uniquely qualified to provide these assessments and interventions.

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