The 'picky eater': The toddler or preschooler who does not eat

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The majority of children between one and five years of age who are brought in by their parents for refusing to eat are healthy and have an appetite that is appropriate for their age and growth rate. Unrealistic parental expectations may result in unnecessary concern, and inappropriate threats or punishments may aggravate a child's refusal to eat. A detailed history and general physical examination are necessary to rule out acute and chronic illnesses. A food diary and assessment of parental expectations about eating behaviour should be completed. Where the child's 'refusal' to eat is found to be related to unrealistic expectations, parents should be reassured and counselled about the normal growth and development of children at this age.

Key Words: *Picky eating; Poor eating; Refusal to eat; Toddler; Unrealistic parental expectations*

Le « mangeur difficile » : le tout-petit ou l'enfant d'âge préscolaire qui ne mange pas.

La majorité des enfants de un à cinq ans pour qui les parents consultent parce qu'ils refusent de manger sont en bonne santé et ont un appétit qui convient à leur âge et à leur rythme de croissance. Les attentes irréalistes des parents peuvent donner lieu à des inquiétudes inutiles, et les menaces et punitions déplacées peuvent aggraver le refus de manger de l'enfant. Les médecins doivent procéder à une anamnèse détaillée et à un examen physique général pour écarter une maladie aiguë ou chronique. Ils doivent demander un journal alimentaire et évaluer les attentes des parents à l'égard du comportement alimentaire. Lorsque le « refus de manger » de l'enfant semble lié à des attentes irréalistes, il faut rassurer les parents et leur donner des conseils sur la croissance et le développement normaux des enfants de cet âge.

Approximately 25% to 35% of toddlers and preschoolers are described by their parents as poor or 'picky' eaters (1-4). Children's feeding and eating problems are a frequent cause of parent-child conflict and can cause tremendous concern for the parents. However, the majority of these children have an appetite that is appropriate for their age and rate of growth (4). Paediatricians and family physicians are ideally positioned to help parents learn to feed children effectively and to provide anticipatory guidance that avoids making mealtimes a daily battleground or reinforcing problematic feeding behaviours.

ETIOLOGY

During the first year of life, an average infant gains 7 kg in weight and 21 cm in length. During the second year of life, growth is about 2.3 kg and 12 cm, with most toddlers reaching an average weight of 12.3 kg and a height of 87 cm at two years of age (5). Between two and five years of age, weight gain slows down. Most children gain 1 kg to 2 kg and 6 cm to 8 cm per year (5). During this period, most toddlers and preschoolers experience a decrease in their appetite (4). Some parents mistake the average weight (the 50th percentile) for normal weight. It is not unusual to find that a child's weight and height are within the normal range (third to 97th percentile) or even above the mean, while parental growth expectations are excessive. Children with smaller builds may have lower food requirements (4).

Most picky eaters are not born that way. Parental efforts to make small eaters eat more may have the opposite effect. Caregivers may pressure children to eat without appreciating the physiological decrease in appetite that occurs between one and five years of age (4). Children's appetites tend to be erratic during these years. Although toddlers and preschoolers vary considerably in their intakes at meals during the day, their total daily energy intake remains fairly constant (6). Healthy children have a remarkable capacity to maintain their energy balance over time when offered an assortment of nutritious foods (6). Parents who believe that their child is abnormally small or nutritionally at risk are more likely to overreact to variations in the child's appetite (7).

As toddlers struggle to develop a sense of autonomy, they prefer self-feeding and become selective in their choice of foods (8). If pressured or forced to eat, children's need for autonomy may lead them to resist eating (7).

Young children tend to be neophobic – they do not like new foods (8) – and are often perceived as picky eaters by their parents. Despite the initially negative reactions to new foods, they do learn to accept them with time and repeated, neutral exposures (7,9).

Excessive intake of beverages (eg, milk, fruit juice) or sweets can reduce a child's appetite for food, displace more calorie- and nutrient-dense foods and, in some children, may lead to failure to thrive (10,11). 'Grazing' between planned meals and snacks can also interfere with a child's appetite.

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In some children, food refusal may be an attention-seeking device (4). This behaviour may also be an indicator of difficulty in the parent-child relationship (7). There is evidence of an inverse relationship between a family's dysfunctional environment and children's dietary intake (12).

Refusal to eat may also result from inappropriate feeding techniques. Strategies such as threats, prodding, scolding, punishment, pleading, bribing, or coercing will reduce rather than increase the intake of food (8,13). Verbal praise or a loving look are considered positive in developing food likes (4,13).

Most children like to copy others. The family and a child's peers are role models for the development of food preferences and eating habits. If a family member or another child refuses a specific food, the toddler may imitate this behaviour (4). Family and peer group modelling are effective not only in encouraging reluctant children to eat, but are also a potent resource for increasing the range of accepted foods (14).

Mealtime atmosphere is important to the eating behaviour of a child. Guidance and tolerance have a positive effect, while distraction and quarrelling are negative (15). Insistence on mealtime behaviours and table manners that are inappropriate for the child's age may also interfere with the child's eating (3).

CLINICAL EVALUATION

Taking a detailed history is necessary for determining whether the refusal to eat results from a physiological decrease in appetite or from an organic cause. A detailed three- to seven-day dietary history can help to estimate the child's caloric intake. Typical portion sizes, the time taken to finish a typical meal and the mealtime atmosphere should be noted. If specific foods are eaten well on one day and refused the next, the problem is often one of unrealistic expectations (4). When a decrease in appetite is a manifestation of an organic disease, it often appears abruptly and relates to all types of food. A complete functional enquiry is important to rule out the possibility of the many acute or chronic illnesses that are associated with anorexia. Some medications can also cause loss of appetite.

A thorough physical examination is essential to look for signs of poor nutrition and to rule out an underlying condition causing the decrease in appetite. Accurate measurements of weight and height and a comparison with previous measurements, and a determination of weight for height or body mass index, should be made. If the child looks well and is growing normally, the refusal to eat is most often physiological. Although the physical examination usually confirms the general well-being of the child, most parents are unconvinced by reassurance that is not preceded by a careful physical examination of their child.

MANAGEMENT

The underlying cause(s) of food refusal should be treated whenever possible. When the refusal to eat is due to unrealistic parental expectations, the following advice may be helpful:

1. Reassure parents that a decrease in appetite is normal for children two to five years of age and that their food consumption moderates to match a slower rate of growth.
2. Explain that while parents are responsible for which foods children are offered to eat, the child is responsible for how much to eat (7). In other words, parents should choose nutritious food of appropriate texture and taste for the child's age, and provide structured meals and snacks, but allow children to decide how much and what to eat. Parents need to be flexible and allow food preferences, within reason, as long as their child maintains appropriate growth. Although food intake may fluctuate considerably from day to day in toddlers, they are able to maintain stable growth (3).
3. Emphasize that it is a good idea to give, initially, relatively small portions of each food at meals. A general rule of thumb is to offer one tablespoon of each food per year of the child's age and to serve more food according to the child's appetite (15). If the child finishes everything on the plate, more can always be added.
4. Reinforce that snacks work best mid-way between meals and should not be offered if the timing or quantity of snacking will interfere with the child's appetite for the next meal (16). Snack foods that are dense in nutrients should be chosen. Juice should not be offered as a part of the snack. Children should NOT be allowed to graze throughout the day or to drink an excessive amount of milk or juice; both practices lead to eating less at mealtimes.
5. Remind parents that eating should be an enjoyable activity. Children should not be coerced or even coaxed to eat (14,17). Bribes, threats or punishments have no role in healthy eating (4).
6. Suggest that the toddler's time at the table should generally be limited to about 20 min (14). When mealtime is over, all food should be removed (18) and only be offered again at the next planned meal or snack (18). It is unlikely that the subsequent meal will be refused (3).
7. Highlight that to stimulate appetite, children need exercise and play. However, they are less likely to eat well when they are tired or overstimulated (16). A 10 min to 15 min notice before any meal helps children to prepare and settle down before eating (4).
8. Remind parents that distractions such as toys, books or television at the table should not be permitted during mealtimes (4,19).
9. Parents should only insist on table manners that are appropriate to the child's age and stage. Meals should be pleasant family times. Parents should try not to make discipline an issue at mealtime. A child who is crying or upset is unlikely to eat well.
10. Eating with the family provides the toddler with a pleasurable social experience and the opportunity to learn by imitation. Children value the company of family members and depend on their presence to do well with their eating (7). Families should eat together whenever possible.
11. Appetite stimulants such as cyproheptadine are generally not indicated for isolated food refusal and should never be considered solely to alleviate parental anxiety. Vitamin or mineral supplements can be used if the quality of the diet is questionable. When a child is growing well there is no role for nutritional supplements such as special formulas for toddlers and children. Special toddler formulas are no substitute for eating healthy foods, as recommended in Canada's Food Guide (www.healthcanada.gc.ca/foodguide).

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