Introduction

On 1st March 2010 a UK national conference was held at Great Ormond Street Hospital (London) on the subject of feeding problems of clinical significance. It was a successful conference with many delegates in attendance from a wide range of professional backgrounds. What dominated the question and answer session of the day was 'what to measure in clinic'. In effect, the delegates wanted to know what evidence we have that a particular child needs help and, moreover, how can we provide evidence for it through objective behavioural measures. The British National Health Service is increasingly dictating that evidence is required for the identifying pathologies, medical or psychological, prior to offering any intervention. Unfortunately, the referral from one professional to another does not count as evidence. It would appear that the attendees at the conference are unsure about appropriate measurement criteria for feeding problems of clinical significance. This is understandable as even a brief foray into the literature will reveal that a number of measures are available and studies lack consistency in defining the term "feeding disorder" (if it is actually used) or how to measure it.

In the current healthcare environment, the usage of the term "clinical eye" for assessment is met with increasing resistance by advocates of evidence-based practice. Usually the term "evidence-based" can easily be replaced with the doctrines of positivism and quantitative/statistical methods and applies to both the need for treatment and efficacy of intervention. In short, the clinician is required to integrate their expertise with the best evidence gained from systematic reviews of the most recent relevant research findings. Compounding this recent upsurge in the desire for an evidence-base, there has been significant criticism of the diagnostic criteria for feeding disorders. Published criticisms of how the diagnostic term 'feeding disorder' relates to observed clinical loads has received positive affirmation from specialists resulting in alterations proposed in the Diagnostic and Statistical Manual V (DSMV). These alterations reflect the addition of a
lack of dietary variety as well as quantity, as a diagnostic criterion, as well as understanding the psychosocial functioning of the child and how their feeding behaviour impacts on their family dynamic\textsuperscript{3,4}.

It is understandable that trainees and specialists from non-psychological fields are confused about what measures to use to assess children’s behaviour who present with feeding difficulties. Those that consult the literature find that there is an overwhelming bias for diagnosis through terms such as ‘clinical evaluation’\textsuperscript{5}, ‘clinical assessment’\textsuperscript{6} or ‘referred to centre’\textsuperscript{7}. Usually, these terms are accompanied by methodologies such as feeding behaviour/interaction observations using various coding systems\textsuperscript{6, 8-10}. The implementation of these various terms, diagnostic or otherwise, and accompanying coding scales often determine the success of the intervention by the child’s weight\textsuperscript{11}, number of bites accepted\textsuperscript{7,12}, amount consumed\textsuperscript{13} and/or meal duration. This process is necessary, but has two clear weaknesses: 1) First, it neglects the dyadic and family dynamic components to the feeding problem and second, 2) it is reliant on the clinician’s interpretation and perception of behavioural improvement. Improvement in this instance refers to the child’s current feeding behaviour compared to their previous behaviour. Instead, of ‘knowing’ that the child’s feeding has returned to something resembling normal eating, the inference is that the problems have comparatively diminished or the child’s weight has increased. Without providing some form of quantification of the change based on a comparison to a ‘normative’ population, this assumption, although it may be accurate, does not provide a best practice model in an evidence-based healthcare setting.

Compared to other psychobiological problems, co-morbidity of significant and pervasive feeding problems is often accompanied by additional diagnoses that supersede the feeding problem in isolation. Common co-morbidities/explanations for the feeding problem derive from gastroenterological problems\textsuperscript{14}, autistic spectrum disorders\textsuperscript{15} and developmental delay\textsuperscript{16}. Therefore, health professionals situated in centres specialised on disorders associated with feeding problems require access to evaluative measures found in the specialist literature. This is clearly not occurring if the conference attendees were indicative of a wider audience.

This short article will briefly consider the pen and paper measures available within the literature for feeding disorders/problems. Physical assessments and measures have been reviewed elsewhere and interested parties are referred to this source\textsuperscript{17}. It is acknowledged that offering opinions on various measures will elicit debate from advocates of one measure over another. This debate can only be a good thing and this article is not an attempt to limit this discussion. Based on the reliance on opinion and interpretation of measures within this article, it is important that the reader acknowledges that this is only ‘a way’ rather than ‘the way’ of measuring feeding problems. Furthermore, this discussion will be limited to the methods only. Adherence to one specific definition or grouping strategy of feeding disorder(s) will be avoided in an attempt to provide clarity in regarding methodological measurements.

From the conference, there appears to be a strong desire amongst practitioners to offer a standardised measure to delineate a feeding problem requiring clinical intervention from normal feeding difficulties, as well as provide some form of quantitative evidence for effective alteration in the child’s behaviour after intervention. What became apparent within the conference was that the preferential measure used by a number of professional groups was the Child Food Neophobia Scale (CFNS)\textsuperscript{18}. This scale has some significant weaknesses when used to assess children with feeding problems of clinical significance. Foremost amongst these problems is that it has not been psychometrically validated on a clinical sample.

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**A call for articles**

We need submissions for future issues of The Feeding News. Tell us about your clinic/program, treatment ideas, clinical moments, review an interesting article or book, etc. If it’s of interest to you and your colleagues it will be of interest to others.

Many thanks, Anne
Feeding Measures Available in the Literature.

A plethora of questionnaires measuring various aspects of children’s feeding behaviour are available within the literature. Some of these questionnaires are quantitative, and thus serve the evidence-based prerequisite, while others are purposeful in nature created for the specific study in question. In no particular order, the psychometric measures that have been used in the feeding problem/disorder literature are: Child Eating Behaviour Inventory (CEBI)\(^{19}\); Behavioral Pediatrics Feeding Assessment Scale (BPFAS)\(^{20}\); Child Feeding Assessment Questionnaire (CFAQ)\(^{21}\); Child Eating Behaviour Questionnaire (CEBQ)\(^{22}\); Food Frequency Questionnaire (FFQ)\(^{23}\); Child History Questionnaire (CHQ)\(^{24}\); Feeding Resistance Scale (FRS)\(^{24}\); Feeding Scale (FS)\(^{24}\); Oregon Research Institute Child Eating Behaviour Inventory (ORI-CEBI)\(^{25}\); Child Food Neophobia Scale (CFNS)\(^{18}\); The Ramsay Feeding Questionnaire (TRFQ)\(^{26}\); and feeding scales specifically designed for the particular study\(^{27-29}\). The diverse number of measures, complete with questionnaire total items ranging from 6-139, makes filtering out important information an obvious hurdle to the clinician who has little time to decide the most appropriate measure to adopt prior to intervening.

The method we use to delineate the most appropriate measure is:

1) Only use a questionnaire that has withstood the rigours of psychometric testing. Psychometric testing essentially refers to quantification of the various forms of validity and reliability.

2) Use those questionnaires that have been psychometrically defined as being able to differentiate clinical cases from the general population.

3) Preferentially employ measures specific to the clinical group (i.e. the one that shows the most potential variation within the target group and from the non-clinical group. Simply being at the extreme limits of a measure removes the potential to differentiate clinical severity at presentation).

4) Choose measures that can be quickly administered and analysed.

5) Identify measures that have the potential to vary over the course of the intervention.

These arguably simple criteria would offer the clinician the ability to gain a lot of information quickly for little effort, as well as providing a measure of efficacy. However, to our knowledge, few of the measures listed so far would meet all of these criteria. If we consider detailed psychometric testing as the primary variable, so we can ensure that we have evidence for reliability in the measure, then the potential list of measures dramatically reduces. Those that survive this first criterion are CEBI, BPFAS, CEBQ, FFQ, and CFNS. After the second point, only the FFQ will fall down. Application of the third criterion leaves us with two measures – BPFAS and CEBI. Although the other measures, the CEBQ and CFNS, have been used with clinical samples, they were neither devised for nor specifically validated in children with feeding problems. Each of these ‘other’ measures, although accurate in what they measure and having been frequently used in numerous publications, are devised for use in the general population. They are designed to measure normal behaviours. The potential variation in outcome for children with clinical feeding problems measured through a scale that is based on normal population will only reveal that the child is an extreme scorer. The children are likely to score highly, possibly a maximal score on the measure, and even once sufficiently recovered are less likely to show large variations against the general population mean.
The CEBI and BPFAS are able to transcend through each of the five criteria detailed. The creators of these two questionnaires do not advocate the use of their measure to differentiate clinical significance from non-significance. Instead, they advise that their measures are to be used on a continuous scale. The reluctance for anyone to suggest that a psychometric measure should be used in isolation to identify a child as having a clinically significant problem probably stems from the perceived potential for misdiagnosis. However, one could comfortably advocate that a psychometric measure could, and indeed should, be used as an indicative and comparative tool rather than to diagnose. Diagnosis should be appropriately left to clinical observation of the behaviour against diagnostic criteria. As an example for potential misdiagnosis, parental reports of children with medical-related feeding dysfunction on the BPFAS and CEBI tend not to score as highly as parents of children with predominantly behavioural-related problems.

Both the BPFAS and CEBI are similar questionnaires with similar methods of administration and analysis. The personal preference and differentiation between the CEBI and BPFAS derives from the additional outcomes offered with the BPFAS compared to the CEBI and the ability to differentiate between clinical versus non-clinical groups. The CEBI offers two potential subscales following administration. These are an eating problem score and perceived problem score. In contrast, the BPFAS offers a total behavioural frequency score and a perceived problem score, but these are derived from parent-related factors and child-related subscales. Furthermore, in the original paper\textsuperscript{20}, there are some indications of additional subscales related to picky eaters, general refusal, textured food refusal (for toddlers) and stallers (for older children). These additional factors, alongside the differentiations between parent-related and child-related subscales, offer additional strengths for the administration of the BPFAS that are not present in the CEBI. However, it must be noted that the picky, staller, general and texture subscales have not been adopted in subsequent investigations using the BPFAS. Based on the original psychometric evaluations of the two measures, the CEBI finds it difficult to differentiate between clinical and non-clinical samples in terms of frequency of eating problems, although it does have the ability to show significant differences in mean scores. Furthermore, only a small percentage of the items on the CEBI were reported as being of clinical significance (22% in clinical sample compared to 13% in controls)\textsuperscript{19} compared to the BPFAS (44% and 8% respectively)\textsuperscript{20}. Both the CEBI\textsuperscript{30-32} and BPFAS\textsuperscript{28, 33,34} have been used in clinical samples, however, only the CEBI has been shown to vary following interventions\textsuperscript{30}. The evidence indicates that the change in scores on the CEBI following intervention is in the region of five points on both the eating problem (scores range from 40-200) and perceived problem subscales (scores range from 0-40)\textsuperscript{30}. In our clinic, we have unpublished data from our clinical practice.

<table>
<thead>
<tr>
<th>How many Questions?</th>
<th>What Does it Measure?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Pediatrics Feeding Assessment Scale (BPFAS)</td>
<td>Total Frequency of Behaviour \nChild-Related Frequency of Behaviour \nParent-Related Frequency of Behaviour</td>
</tr>
<tr>
<td>35 items</td>
<td>Total Problem Score \nChild-Related Problem Score \nParent-Related Problem Score</td>
</tr>
<tr>
<td>Child Eating Behaviour Inventory (CEBI)</td>
<td>Eating Problem Score \nPerceived Problem Score</td>
</tr>
<tr>
<td>40 items</td>
<td>Perceived Problem Score</td>
</tr>
</tbody>
</table>

Table 1 – Psychometrically validated questionnaires for feeding behaviour in clinical samples.
indicating that scores on the BPFAS are responsive to interventions and respond to a much greater variation than the CEBI$^{35}$. We have found that the scores will differ by around fifty points on the frequency of total problem behaviour (scores range from 35-175) and seventeen points on the perceived problem subscale (scores range from 0-35). However, it is accepted that this may be confounded by different ‘types’ of intervention.

Our preference for the BPFAS derives from four main strengths, which are:

1) It has a comparatively strong psychometric profile.

2) It has additional subscales on parent- and child-related factors for feeding problems.

3) It has a better profile at differentiating clinical and non-clinical groups.

4) It has a better ‘intervention change’ profile in our currently unpublished research and clinical work.

The most obvious criticism of the interpretation of the utility of the CEBI and BPFAS over the previously rejected questionnaires is that those initially rejected do not claim to measure the same constructs. The two questionnaires that survived the five criteria may differentiate problem eating behaviour from normal eating behaviour but they do not go beyond this. Therefore, responsiveness to intervention will only reveal that the child has moved out of the problem score category and into more normative values. The three rejected questionnaires that have a strong psychometric profile in normative samples of children – the CEBQ, FFQ and CFNS – may aid in providing additional data concerning the efficacy of clinical interventions. For example, the FFQ may differentiate selective eaters from those that do not eat sufficient quantity, and may provide the clinician with the ability to quantitatively measure effective dietary variety intervention outcomes. However, the FFQ’s utility diminishes against the superior professional dietetic evaluations of the child’s habitual diet. We would not advocate undermining the need for multidisciplinary assessment by using the FFQ instead of dietetic evaluations; instead, we would suggest that these measures could be used to provide a structured context for parents who may be completing measures in an outpatient setting or providing intermediary evidence during parent-led interventions.

Table 2 - Psychometrically validated questionnaires with the potential to aid in measuring the efficacy of interventions

<table>
<thead>
<tr>
<th>How many Questions?</th>
<th>What Does it Measure?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Eating Behaviour Questionnaire (CEBQ)</td>
<td>35 items</td>
</tr>
<tr>
<td>Food Responsiveness</td>
<td></td>
</tr>
<tr>
<td>Enjoyment of Food</td>
<td></td>
</tr>
<tr>
<td>Satiety Responsiveness</td>
<td></td>
</tr>
<tr>
<td>Food Fussiness</td>
<td></td>
</tr>
<tr>
<td>Slowness in Eating</td>
<td></td>
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<tr>
<td>Emotional Over-Eating</td>
<td></td>
</tr>
<tr>
<td>Emotional Under-Eating</td>
<td></td>
</tr>
<tr>
<td>Desire to Drink</td>
<td></td>
</tr>
<tr>
<td>Food Frequency Questionnaire (FFQ)</td>
<td>139 items</td>
</tr>
<tr>
<td>Dietary Variety</td>
<td></td>
</tr>
<tr>
<td>Child Food Neophobia Scale (CFNS)</td>
<td>6 items</td>
</tr>
<tr>
<td>Reluctance to try novel foods.</td>
<td></td>
</tr>
</tbody>
</table>
The CEBQ contains eight subscales concerned with different aspects of eating behaviour. These are: food responsiveness; enjoyment of food; satiety responsiveness; food fussiness; slowness in eating; emotional over-eating; emotional under-eating; and desire to drink. Although the child may initially score extremely high or low on each of these subscales respectively, the CEBQ may provide a strong context to differentiate children at presentation and/or uncover the component of the feeding problem that an intervention improves. For example, a child with a medically-related feeding problem may vary on their responsiveness to food. Children who do not eat because they rely on enteral support yet are still curious about food, are likely to respond to treatment protocols faster than those that are not curious. In addition, improvement in dietary variety may be observed in lower levels of food fussiness. Finally, improvement in satiety responsiveness and slowness in eating will indicate significant improvement in prognosis and that the child has responded to interventions by reaching and responding to satiety and satiation cues and decreasing their meal duration.

We have found that the CFNS can provide evidence for older children that present with comparatively high levels of anxiety around food compared to other clinical groups. Food phobia and food neophobia, although conceptually different from one another, are somewhat intertwined. Food phobia would be an extreme anxiolytic response to specific or general food groups derived from a significant life event (e.g. choking) or a generalised anxiety disorder. Food neophobia, in contrast, would be the reluctance to eat, or avoidance of, new foods and is a normal developmental milestone. The two concepts do however share similar characteristics in the form of the reluctance to eat or avoidance of food. Therefore, measuring the reluctance to try foods through the CFNS, taps into a potentially valid measure of treatment effectiveness in some instances.

In the absence of a specifically designed psychometrically valid questionnaire for use by clinicians working with children presenting with clinically relevant feeding problems, we are somewhat reliant on ‘borrowed’ measures. Currently, clinicians have specific measures to potentially differentiate between those children with a feeding problem and those without and the BPFAS may provide an evidence-base for efficacy in successful interventions. Beyond this dichot, albeit sensitive, assessment for feeding problems of clinical significance other measures may provide insights into the efficacy of various treatment protocols.

**Measuring Beyond Feeding**

Assessing feeding problems in isolation is not always appropriate. As mentioned in the introduction, feeding problems often manifest with complex aetiology and presentation. Understanding the complexity of the precipitating, predisposing and maintaining factors will offer greater insights into prognosis from the outset. In an environment where the clinician must provide an evidence-base for treatment efficacy, it is equally important to understand why some children do not respond as quickly as others to a particular treatment. Understanding potential response times will also allow for a better management of family expectation.

Frequent behavioural co-morbidities associated with clinical feeding problems include social interaction problems, sensory sensitivity and challenging temperament. Additional co-morbidities also exist, but these are less responsive to interventions. These include problems such as developmental delay, autism and medical, usually gastrointestinal, ailments.
Table 3 - Psychometrically validated questionnaires with the potential to explain inter-individual differences in interventions

<table>
<thead>
<tr>
<th>Questionnaire</th>
<th>How many Questions?</th>
<th>What Does it Measure?</th>
</tr>
</thead>
<tbody>
<tr>
<td>EAS Temperament Survey for Children (EAS)</td>
<td>20</td>
<td>Emotionality</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Activity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Shyness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sociability</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Emotional Symptoms</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Conduct Problems</td>
</tr>
<tr>
<td>Strengths and Difficulties Questionnaire (SDQ)</td>
<td>25</td>
<td>Hyperactivity-Inattention</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Peer Problems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prosocial Behaviour</td>
</tr>
<tr>
<td>Infant/Toddler Sensory Profile (ITSP)</td>
<td>48</td>
<td>Sensory Processing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sensory Processing Quadrants</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tactile Sensitivity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Taste/Smell Sensitivity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Movement Sensitivity</td>
</tr>
<tr>
<td>Short Sensory Profile (SSP)</td>
<td>38</td>
<td>Auditory Filtering</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Low energy/Weak</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Under-reactive/Seeks Stimulation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Visual/ Auditory Sensitivity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total Sensory Score</td>
</tr>
</tbody>
</table>

Fewer measures for social interaction, sensory sensitivity and temperament exist and these features are not the primary reason for the involvement of feeding-related clinicians in the child’s care. This leads to less contention when advocating one measure over another. Our preferred questionnaires for measuring these behavioural components are the Emotionality, Activity and Sociability Temperament Survey for Children (EAS) scale, the Strengths and Difficulties Questionnaire (SDQ) and the Infant/Toddler Sensory Profile/Short Sensory Profile (ITSP/SSP). Understanding the child’s sociability, sensory difficulties and temperament provides additional information about the identified barriers to treatment. Sensory sensitivity is an increasingly common and consistent theme in both feeding research and clinical practice. Children presenting with any form of sensory defensiveness (oral, tactile, olfactory, visual or a combination of the senses) as an integral component to their low dietary variety and/or current weight status must be appropriately assessed. In order to acknowledge the severity of the sensory defensiveness from a quantitative perspective, the psychometric measurement of the child’s sensory defensive characteristics can be performed using an appropriate (dependent on the age of the child) form of the Dunn Sensory Profile. We find that this measure provides a good indication of the sensory defensive characteristics of the child; however, it has the significant drawback of being commercially copyrighted – it must be purchased prior to administration. This draws on valuable and limited resources.
of some feeding clinics. A free-to-access psychometrically valid and reliable sensory measure would be helpful for the field going forward.

Common strategies for primary and secondary level interventions in the UK are often based on structured messy play\(^{45}\). The feeding specialist is situated at the tertiary level. This intervention is more-often-than-not performed with groups. The addition of an unsociable child to any of these group interventions may have a significant impact on the overall outcome for the group. Measuring sociability with the SDQ and EAS prior to offering group interventions may provide a quick way of ensuring that unsociable children are not grouped together with highly sociable individuals. This prohibits the potential for ‘cross-contamination’ and partially ‘undermining’ the potential efficacy of the intervention by adding together children of mixed sociability and temperament.

The child’s temperament is likely to have an impact on the duration and efficacy of the any intervention\(^{46}\). Children with high levels of emotionality and activity will inherently have additional difficulties compared to their lower scoring counterparts. Through understanding and quantitatively measuring temperament, additional evidence as to potential child-related barriers to successful intervention will be provided.

Measuring behaviours beyond feeding during a clinical intervention may be helpful in understanding additional individual difference-related characteristics of the child. Providing evidence for the efficacy, value and specificity of any intervention is important and can be gained through specific feeding-related measures. To fully understand the effectiveness of any given intervention, a clinician must be able to predict the relative timeframe that change will be observed in. This cannot be fully understood through just measuring the feeding problem or its comparative severity on presentation. Additional measures of sociability, sensory sensitivity and temperament may offer additional evidence for the variation in duration of any given intervention.

**Limitations of Questionnaires in Used Feeding Clinics**

Questionnaires are limited by the fact that they are:

1) Reliant on parental-report

2) Reliant on parental educational attainment

3) Only proxy measures for behaviour

4) Can be repetitive and burdensome

The obvious limitation of questionnaires for children’s behaviour is that they are reliant on parent-report. Therefore, some of the variation in the scores on the psychometrics will derive from factors inherent to the parents. Parental characteristics, anxiety, pathology and desire for professional support may result in scores that are elevated compared to clinical observations. The questions answered by the parents about their own child are bound up with the parent’s perception, which can be marred by any number of factors. The parents will not necessarily understand the meaning of the term severe or persistent feeding problem. Transient or severe experiences may be globalised from ‘sometimes happening’ to ‘always happening’. Alternatively, parents may not consider or even observe some their child’s problematic behaviours because of fixation on the child’s limited diet. On the questionnaires, this will lead to higher or lower scores respectively.

Parental language, education, literacy and intellect will also provide a barrier to obtaining accurate data from psychometric questionnaires. Furthermore, alternative primary caregivers such as foster parents,
grandparents or significant others who are not aware of the history of the child’s feeding behaviours are also unlikely to be able to provide accurate questionnaire results. Ensuring that the correct individual who actually feeds the child completes the questionnaire is of paramount importance. Although this may be perceived as an obvious statement, in the modern family setting where both parents work it may not be the parent that ordinarily feeds the child. Other significant individuals, such as school staff or extended family members, may be feeding the child more often than the individual that attends the clinic or may be responsible for providing meals with a highest calorific content. In such situations, it would be more appropriate that these individuals complete the questionnaires.

Another limitation is that questionnaires are proxy measures for behaviour. Questionnaires are without parallel for providing quick data on the child’s feeding behaviour; however, they are not a replacement for professional clinical observation. The strength of the questionnaire is in its speed to complete and its ability to present the child’s behaviour numerically for fast dissemination to all individuals involved in the clinical setting. By its very nature, the questionnaires in general have an inherent error. That is, it is not one hundred percent accurate. The perfect questionnaire that fully characterises a child’s feeding behaviour does not exist. In the individually-determined world of the clinical intervention, a questionnaire will not reveal many of the qualitative components to the child’s feeding behaviour. These qualitative feeding differences from ‘normal’ children are arguably those that ‘flagged’ the child for professional attention and the rectification of these behaviours will be the true measure of successful intervention. The questionnaire cannot always show these differences.

The final significant limitation of the psychometric evaluation of a child’s feeding behaviour is that the measures can often be repetitive and burdensome on the parent. Carefully controlling the rate and presentation of different psychometric questionnaires is important for valid data. Offering too many measures at one time or administering them too frequently will significantly undermine the value in the data obtained. In feeding interventions, there is a need to rely more on the feeding measures than those considering other characteristics. The clinician may find value in offering the BPFAS, EAS, SDQ and ITSP at different times and in different frequencies.

Conclusions

Anecdotally (based primarily on the conference attendees and conversations with numerous centres and professionals in the UK), problems in definition and the concomitant methodological differences amongst published studies may have created a significant barrier to gaining access to appropriate psychometric questionnaires to measure feeding problems. From this simple assessment of the measures available, there are only two potential resolutions. Either, the feeding specialists provide detailed training for other professional groups on how to implement and infer data from the clinical observation or another method of initial assessment must be offered. It is clear from the literature that some psychometric questionnaires are readily available for use with children who have significant feeding difficulties. Although not all of these measures are psychometrically extrapolated from clinical samples, some are and those that are not can be applied in a different manner. The use of a psychometric questionnaire also has the added advantage of being based on parent-report rather than clinical perception, which, in an evidence-based healthcare system, can provide a quantitative pseudo-objective rationale for professional intervention and assess the efficacy of the clinician’s work.

The objective of this article was to offer guidance on which measures to use for clinically significant feeding problems. Although advocates for other psychometric measures may disagree with the opinions offered here, what is indisputable is that it is necessary to measure problem feeding behaviours. Whether the health professional’s centre preferentially administers the CEBI or the BPFAS is not important. What
is important is that they measure the child’s feeding behaviour before, during and after the intervention. If they have the potential to offer multiple types of intervention for feeding problems of clinical significance based on a specific grouping or diagnostic category, then additional psychometric measures may help identify the most appropriate intervention. As a minimum, they may explain potential inter-individual differences in intervention outcomes.

In conclusion, employing a psychometric questionnaire at the appropriate time may save the clinician time and effort in gaining rich data to determine efficacy of their intervention. This in turn will ensure that others can access the outcomes even if only on a surface level. Although observed behaviours and physical characteristics (weight status, meal duration, meal size etc...) may improve, only through psychometric questionnaires can the professional show to outside parties that they were responsible for the change.

References


