11030-101 Raven Ridge Road, Raleigh, NC 27614 Phone: 919-844-6611

# TYPICAL FEEDING DEVELOPMENT

**How should my child be eating at different ages?**

0-4 months:

- Exclusively breast or bottle fed
- Feedings take 30 minutes or less
- Rooting reflex present—turns toward the nipple when the cheek is stroked
- Coordinates 2-3 sucks from the breast or bottle before taking a breath

4-6 months:

- Primarily breast or bottle fed
- May introduce infant rice or oatmeal cereal
    - Anterior loss is to be expected

6-8 months:

- Continue with breast milk or formula
- Anticipates the spoon by opening the mouth upon presentation
- Clears the spoon with the upper lip
- Efficiently swallows smooth puree (stage 1, 2) 1-2x/day with a suckle pattern
- Introduce dissolvable crackers—emergent lateral munching

9-10 months:

- Continue with breast milk or formula from the bottle
- Tolerates textured puree (stage 3, mashed table foods)
- Begins to self-feed with dissolvable solids—lateral munching pattern established
- Accepts sips of liquid from an open cup with assistance

10-12 months:

- Continue with breast milk or formula from the bottle while beginning to transition to an open or sippy cup for liquid intake
    - Tongue may protrude under the lip of the cup to provide increased stability
    - Can drink from a straw
- Continue to accept textured purees
- Tolerates a wider variety of soft solid textures with an open mouth lateral munching pattern
    - Examples: Crackers, Bread, Diced Fruits & Vegetables, Cheese

12-18 months:

- Transitions fully from breast milk or formula to cow's milk from an open or sippy cup
- Primary source of nutrition is soft table foods
- Eats a wide variety of flavors

18 months and beyond:

- Self feeds table foods with fingers
- Increasingly efficient with self-feeding with utensils
- Drinks from an open cup with the ability to take repetitive sips
- Eats a wide variety of flavors and textures with increased bite strength allowing for mastication of meats

**Red flags that would warrant a feeding evaluation include:**

Birth-4 Months

- Difficulty swallowing
- Stressful feeding
- Weight loss or failure to thrive
- Color changes during feeding
- Choking or coughing during feeding
- Gagging and/or vomiting during or after feeding
- "Sleep feeding"
- Lengthy mealtimes
- Limited volumes

4-6 Months

- Gagging with spoon feeding
- Aversive behaviors
- Blocking spoon placement
- Stressful feeding

6-9 Months

- Refusal to advance through different textures
- Limited of interest in crunchy foods

9-12 Months

- Refuses soft, mashed table foods or stage 3 purees
- Gagging on textured purees
- Chokes on solids
- Food present in diapers

12-18 Months

- Extremely picky
- Chokes or gags with feedings
- Grimaces while swallowing
- Spits out chunks of food
- Pockets food in the mouth

18+ Months

- Highly selective by food category or texture
- Unable to drink from an open cup
- Continues to rely on the bottle for hydration

**"Why is my child not meeting his developmental milestones for feeding?"**

There can be a variety of reasons that children may have delayed feeding skills. Approximately 40% of children will experience some degree of delay in the area of feeding development. There is not always a known or suspected etiology; however, some of the more common causes are listed below and are topics of other informational handouts.

1. Gastroesophageal reflux disease (GERD): Infants and children who experience pain and burning due to GERD are highly prone to feeding difficulties because they perceive feeding as an unpleasant experience and do not seek out the oral exploration required to develop mature feeding patterns. Even after GERD is treated medically, children may continue to have food aversions resulting from the learned pain response.
2. Chronic constipation: Infants and children who are prone to constipation have reduced appetite because they constantly feel full. When a child is constipated, he/she may associate feeding with increased abdominal pain and discomfort and will be less likely to accept foods that challenge him/her to advance

to more difficult food textures. Even after constipation is resolved, some children will continue to experience feeding difficulties due to the previous associations with pain.

3. Food allergy/intolerance: Infants and children who experience pain or discomfort due to food allergy/intolerance are more susceptible to feeding delays because they develop negative associations with feeding and do not actively participate in oral exploration. Even after the problem foods are eliminated from a child's diet, children may continue to have aversive behaviors at meals due to a continued fear of pain.
4. Sensory aversions: Some children do not like the feeling of certain food textures and have hypersensitive responses. If they cannot tolerate touching a food, they will not be able to tolerate putting it into one of the most sensitive areas of the body, the mouth. Some of these children may gag and/or vomit at the sight or touch of a challenging food. For children with significant sensory aversions, it is beneficial to work with a speech-language pathologist and an occupational therapist to address feeding concerns.
5. Delayed oral motor skills: If a child does not possess the oral control, movements, and strength to adequately position, transfer, chew, and swallow different textures of food, he/she will likely plateau at a certain level of difficulty.
6. Oral hyposensitivity: When children who have low tone and reduced oral sensation, they are more at risk for pocketing food in the mouth or swallowing a food whole or semi-whole. For children who pocket food, they will likely experience issues with advancing to more textured foods as the need for chewing increases and may have slow weight gain. In children who have a diminished gag reflex, they may attempt to swallow a food whole which places them at a high risk of airway obstruction.