CHAPTER THIRTY

NUTRITIONAL ISSUES AND INTERVENTIONS FOR CHILDREN WITH SPECIAL NEEDS

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Introduction

There is a global trend toward better nutrition and eating healthier meals. Consuming a diet that contains all the necessary food nutrients is necessary for adequate nutrition. According to Mela (2011), a diet that delivers all the essential nutrients and calories required to sustain excellent health and a healthy body weight is considered to give appropriate nutrition. For children and adolescents to reach their maximum development potential and maintain the right body composition, promote health and well-being, and lower their risk of developing chronic diseases as adults, sufficient nutrition is crucial. For both physical development and the maintenance of physiological processes, children need an adequate amount of energy, protein, and other nutrients. Nutritional requirements often follow children's growth rates. According to Olusanya (2010), growth continues steadily throughout childhood and then increases during adolescence, increasing dietary requirements to keep up with the high growth rate and accompanying rises in lean body mass and body size. Individuals' nutritional needs vary depending on their age, gender, size, and physiological status. Each vitamin serves a particular purpose in a person's body. Malnutrition or overnutrition can result from nutritional intake that is insufficient or excessive compared to an individual's biological demands. According to the World Health Organization (WHO), consuming a diet that contains one or more nutrients in an amount that is either insufficient or excessive can result in malnutrition. In addition to having a positive effect on a child's growth and development, a child's food is crucial for ensuring their general health and wellbeing. According to Tuzun et al. (2013), malnutrition is frequently found to have a high incidence/prevalence in children with disabilities, which may lead to poorer health and development and create a vicious cycle of poor nutrition, disability, and deteriorating health status. Children with disabilities therefore experience nutritional difficulties.

Learning is hampered in children with impairments who are at risk for inadequate nutrition and health issues (Ault, Guy, Rues, Noto & Guess, 2004).

Fatigue, diminished energy or stamina, and short attention span are common traits of children who do not get enough nutrients. Children who suffer from severe malnutrition are more likely to develop sores, get hurt, have poor oral hygiene, and experience constipation, vomiting, and diarrhea (McCammon & Rues, 2010). The child's capacity to operate in both the home and the classroom is undoubtedly directly impacted by these traits. Through early intervention services, it is crucial to address the relationship between healthy eating and improved learning capacity. For a human infant to survive and thrive, they must consume enough nutrients. A child who receives adequate nutrition is more likely to develop at the anticipated rate, have a greater capacity for learning, be able to fend off illnesses, and have the stamina to engage in activities (JADA, 1990). For nutrient intake, children with severe disabilities have many of the same fundamental needs as typical kids, and some may even have higher needs (Ault, Guy, Rues, Noto, & Guess, 1994). However, 10% to 25% of children have nutritional status impairment due to risk factors linked to genetic and/or metabolic abnormalities, birth malformations, infections, exposure to prenatal drugs, or handicapping conditions (Baer, Farnan, & Mauer, 1991). To help children with disabilities and chronic illnesses reach their full potential and live healthy, fulfilling lives, nutrition intervention is seen as a crucial health service. To assist families in addressing and meeting their child's food and nutritional needs, nutritional intervention is also crucial.

It is not simple to meet these children's needs. Feeding a youngster who has nutritional issues is a difficult task. The child's capacity for eating is significantly influenced by their physical traits. This aspect of feeding specifically highlights the mechanical process of obtaining sufficient nutrition. A child's ability to eat depends not just on their physical qualities but also on how they are fed, who feeds them, what they want to eat, and the stress and support that their family is undergoing. The multidisciplinary teams would be better able to grasp the needs of children with impairments and nutritional issues if they had an integrated model to work from. The utilization of an integrated approach to meet the nutritional needs of children with disabilities and their families is not supported by the most recent research.

Families will have to decide whether to implant a feeding tube in some children who struggle to get enough nutrition (Bear, Faman, & Mauer, 2011). In order to meet nutritional requirements, this choice may include surgically inserting a gastrostomy tube straight into the stomach or small intestine (Rempel, Colwell, & Nelson, 2000). Although there is evidence that using a feeding tube can enhance a child's health and quality of life, parents frequently face a tremendous issues in this decision-making process. Families must take into account the fact that many children with severe disabilities will require a gastrostomy tube for feeding and sustenance for an extended period of time or permanently when making their choice. Families of children with disabilities have a wide range of decision-making styles (McBride, Brotherson, Joanning, Whiddon, & Demmitt, 2013). Various levels of risk, ambiguity, and conflict may be present while making decisions for families

of children who are malnourished and disabled. These choices may be taken despite uncertainty about how one's quality of life will change, occasionally in disagreement with experts, and frequently out of concern for unfavourable results (Hoyt, 2022; Stevenson, Gressard, Kocher, & Bella, 2012).

For children with special needs, nutrition programmes have a lasting and ongoing effect. By adding nutrition under Public Law 102-119, the renewal of the Individuals with Disabilities Education Act, Congress has attempted to address the eating and nutritional needs of children with disabilities. The teams providing early intervention services to young children with impairments and their families include experts from twelve different academic fields, including nutrition. Despite the need for services and the implication of a need for services in Public Law 102-119, many schools do not currently have certified specialists to manage the dietary needs of children with disabilities (Rokusek, Prendergast, & Elcvall, 2003). There is not enough evidence to demonstrate how nutrition programs provided in schools benefit the child and family.

In a study by Cross, Oakland, Brotherson, Secrist-Mertz and Linder (2014), it was shown that nutrition programmes have a favourable impact on parents' opinions of them and their children's physical development. According to Cross et al. (20114), 59% of the sample improved their weight-to-height ratios after receiving nutrition assistance. More than a third of the parents also said that the intervention helped them provide for their child's nutritional needs. The Cross et al. (2014) study lends credence to the assertion that nutrition programmes provided in schools benefit both children and families. Ault et al. (2004) presented the idea that children with impairments who are at risk for poor nutrition and health issues have learning deficits. In the child's educational plan, it is crucial to take into account the relationship between healthy eating and improved learning capacity. It is not well-researched who will handle these difficulties or how. The lack of an integrated model that takes into consideration a number of factors that may affect the child's nutritional health is one of the issues with addressing feeding issues for children with disabilities.

In this paper, the writers will discuss the nutritional issues and interventions for children with special needs. Nutrition disorders and compromised nutritional status are common among children with special needs will be discussed under nutritional screening and assessment. Interventions for special needs children will also be enumerated and discussed as the basic dietary skills of a child with special needs can be greatly improved with the help of appropriate interventions, which will also make feeding easier for the caregiver. For the child and family, meals can improve, fostering greater nutrition and growth. The paper will make suggestions that will improve the nutritional issues and enhance the interventions.

Nutritional Screening and Assessment

Children with severe difficulties may experience dietary problems and reduced nutritional status. Nutritional risk affects up to 40% of babies and children

with exceptional needs (Lichtenwalter, Freeman, Lee & Cialone, 2003). In early intervention programmes for infants and toddlers with developmental delays, a survey indicated that 70–90% of the children had one or more dietary risk factors (Position of the American Dietetic Association, 2014). Affected development, fluctuating energy requirements, drug-nutrient interactions, metabolic problems, a reduced ability to absorb nutrients, and inadequate feeding techniques are all signs of nutritional risk (Lichtenwalter, Freeman, Lee, & Cialone, 2003). A healthy child benefits from fewer diseases and better coping mechanisms, as well as increased alertness and stamina to engage in therapies, educational activities, and social contacts. The degree of independence the children is capable of achieving improved nutritional status and feeding abilities. (American Dietetic Association Position, 2014).

Nutritional screening and assessment are essential parts of pediatric healthcare (Bessler, 2015). In order to detect babies and children who appear to have nutrition difficulties or who are at risk for having a nutrition problem, screening is a preliminary assessment of factors related to nutritional status (Klawitter, 2013; Adebisi, 2018). All children with special needs should undergo routine nutrition screenings. As a first step toward nutrition intervention, monitoring, and evaluation, screening offers broad data that can be applied to more thorough nutrition assessment and diagnosis (Leonberg, 2018).

Nutrition Screening

The purposes, prerequisites, and advantages of nutrition screening are numerous. Screening entails gathering initial information in one or more of the following categories:

1. medical history and diagnosis
2. biochemistry test results
3. diet
4. developing feeding abilities
5. behaviour (in connection with feeding)
6. social and economic factors

Without incorporating all the categories or all the necessary data within a category, nutrition screening can still be helpful. According to the environment, human availability, and other resources, the screening processes must be adjusted (Amore-Spalding, 2003). The nutrition screening process should be quick and simple. In order to gather screening data, parent-administered questionnaires and/or interview techniques can be useful tools. A range of people, including the parent or special education teacher/caregiver, public health nurse (PHN), clinic nurse, therapist, social worker, registered dietitian (RD), or dietetic technician (DTR), can successfully do the screening. Initial early intervention screenings can include nutrition screening in order to identify issues and refer patients for evaluation. In order to track growth and nutritional conditions, screenings for infants and children with disabilities need to be conducted frequently. A referral

for a nutrition assessment with an expert is required when a children with a handicap has one or more nutritional risk markers. Indicators of nutritional risk must be precisely defined to prevent over- or under-identification of children who are vulnerable. In addition to nutritional risk indicators' warning signs, parental concerns should be attentively listened to and taken into consideration.

A nutrition assessment is used to gather all the data required to rule out or confirm a nutrition-related condition once a nutritional risk indicator has been discovered through screening. An RD or learning disabilities specialist who specializes in vitamin/mineral supplementation, using a quantum magnetic resonance image analyzer (Adebisi, 2018), or preferably with pediatric expertise and/or specialized training for children with special needs and developmental disabilities, should conduct nutrition assessments. According to the American Dietetic Association's position from 2014, a nutrition assessment entails the comprehensive and in-depth collection and evaluation of data in the following areas: clinical/medical history, food, eating skills development, feeding behavior, and biochemical test data. Risk factors discovered during the nutrition screening are further examined during the evaluation so that a nutrition diagnosis can be formed. The evaluation may also point out problem areas like oral-motor development or behavioral problems that need to be reported for assessment by the proper therapist or specialist. One of the crucial components of a thorough interdisciplinary team evaluation and intervention plan is the nutrition assessment.

Nutritional Issues for Children with Special Needs

Here the writers outline some of the major dietary concerns that children with special needs may encounter and offer ideas, when appropriate, on how to overcome these obstacles. Many children with special needs have a number of health issues they deal with as a result of their disability. We must keep in mind that dietary concerns are as unique as each child, and our goal is to only offer parents and other caregivers a general framework.

1. Obesity

Children with and without special needs may be more at risk for other health disorders due to obesity, which has diverse effects on different children. The risk of obesity is highest among children and adults with mobility issues, intellectual disability, or both (Bandini, Curtin, Hamad, Tybor, & Must, 2015; Chen, Kim, Houtrow & Newacheck, 2010; Ellis, Lang, Shield, et al., 2006). According to the Child and Adolescent Health Measurement Initiative (2007), 20% of children aged 10 to 17 with special healthcare needs and 15% of children of the same age without special healthcare requirements are fat. It may be more challenging for children with impairments to maintain a healthy weight, eat well, and engage in physical activity. This could be brought on by a lack of nutritious food options, problems chewing or swallowing food, or problems with its flavour or texture, by medications that can cause weight gain, weight loss, and changes in appetite, or by physical restrictions that make it harder for a person to exercise. Pain, a lack of

energy, the absence of environments that are accessible for exercise (such as sidewalks, parks, and exercise equipment), and a lack of resources (such as money, transportation, and social support from family, friends, neighbors, and community members) are additional difficulties.

2. Being Underweight

Children with special needs are more likely to be underweight due to a variety of issues, such as swallowing issues. Stunting ranked highly among the many forms of undernutrition among children with physical impairments (WHO, 2021). Due to impairments like cerebral palsy, where muscle spasms burn a substantial amount of calories, some children can have an especially fast metabolism. Dysphagia, or difficulty swallowing, is a condition that needs to be diagnosed by a therapist. In minor cases, the therapist can assist such child in developing a stronger swallowing mechanism; in more severe situations, a feeding tube can be required. Children with impairments were twice as likely to be stunted and three times more likely to be underweight, according to a systematic analysis (Hume-Nixon & Kuper, 2018).

3. Having a Complex Relationship with Food

A child with exceptional needs frequently has unique obstacles to developing a positive relationship with food. A child with autism spectrum disorders, for instance, can have a strong negative reaction to certain flavours, textures, or colours. Those who have Down syndrome, however, may like softer meals due to challenges with swallowing or chewing.

4. Side Effects of Medication

Seventy-five percent of children with special needs use medicine, some of which, particularly anti-depressants, anticonvulsants, mood stabilizers, etc., are connected to weight gain. Therefore, it might be beneficial for parents to ask their child's doctor if there are any alternatives that have less adverse effects. Today, medicine has a completely different meaning. Medication is often thought of providing an immediate "cure," particularly for mental illnesses. According to Fiks et al. (2012), children with complex needs take five times as many drugs as average children. Each person's requirements and responses to their mental handicap are unique. Each of them has personal preferences for what they believe is best for them. The discussion over whether or not to use medicine has been accompanied by a rapid rise in diagnoses, particularly in children. According to the National Center for Health Statistics, 7.5% of children between the ages of 6 and 17 were taking medication for emotional and behavioral issues in 2011–2012. The number of people under the age of 18 who use psychostimulants has also increased fivefold since the 1990s. The number of prescriptions appears to be rising dramatically. Children that fidget and move around while they are seated are considered to be annoying. Children are categorized as hyperactive if they cannot complete a task or piece of homework in one sitting. The next step is to take them to a psychiatrist, where they will receive a rapid diagnosis and vitamin prescription.

5. Genetic Factors

Some form of disability affects between 3 and 10% of children. The variance in the percentage of cases caused by genetic abnormalities may be partially explained by variations in sampling techniques. Despite the fact that disabilities with or without congenital defects are the most common cause for seeking genetic guidance (Rauch et al., 2006) and that in several countries of the world it is regarded as the top socio-economic healthcare issue. Parents must be aware of the connection between genetic factors and obesity. A research by Salvador Carrulla, et al., (2011) stated that 214 children met the inclusion criteria out of the 4,231 liveborns included in the cohort. In almost 90% of the children assessed, a diagnosis was determined. 31 of the children had genetic reasons found, but 19 instances remained unsolved despite thorough investigation. This cohort's total genetic prevalence of intellectual impairment was 0.82%. Because this study was nestled within a cohort, there were many early childhood-related characteristics, and the possibility of information bias was reduced by gathering data with a brief recall interval. Because there was no selection bias in the study, it was possible to identify intellectual disability and estimate how common hereditary causes were in this community. This increased the likelihood of offering appropriate management and/or genetic counseling.

6. Oral feeding dysfunction.

Oral feeding problems can be significantly influenced by behavioural issues. These difficulties can occasionally be plain to see, such as when a youngster taunts, refuses to eat, or throws a fit during mealtime. Other times, when a child has suppressed reflux, the behavioural issues are considerably more perplexing. Maladaptive behaviours should ideally be addressed as soon as they start to emerge. A behavioural plan can assist special needs children in achieving their eating objectives even when food resistance is deeply ingrained. It is important to deal with behavioral issues carefully and precisely when they significantly impede progress toward feeding goals (Cronin & Wright, 2010). By unintentionally increasing the very behaviors that are being targeted for reduction, a generalist strategy may do more harm.

Interventions for Children with Special Needs

The basic dietary skills of a child with special needs can be greatly improved with the help of appropriate treatments, which will also make feeding easier for the caregiver. For the child and family, meals can improve, fostering greater nutrition and growth. Various interventions include:

1. positioned properly while feeding;
2. specialized treatment exercises to enhance fundamental oral motor abilities;
3. specific food varieties or textures that will enhance the child's degree of swallowing capacity and oral motor skills while guaranteeing nutrient intake;
4. customized feeding implements;
5. feeding methods that are tailored (Wolf & Glass, 2021).

Partial or complete nutrition may need to be supplied if the child is still unable to ingest a sufficient amount and/or if it is dangerous for the child to eat. Any dietary treatments should be planned and carried out in coordination with the carers and the other intervention team members. The placement of intervention measures should support caregiver priorities, enhance nutrition, and address underlying oral-motor and feeding issues. Children with low muscle tone or bone problems, such as those with Down syndrome or limited movement, may find it challenging to maintain a healthy weight. In order for your children to develop a taste for fresh, seasonal foods, it is crucial to instill healthy eating habits in them from an early age by limiting their exposure to processed, sugary, and salty meals. Additionally, it is crucial to find out whether there are any local children's nutritional programmes emphasizing the value of a balanced diet. A child with special needs is much more likely to adopt a healthy lifestyle if they understand how sugar, fat, and cholesterol influence their body than if they are just told what they should and should not eat. Children can be taught to eat healthy snacks that have fewer than two grams of saturated fat or more than three grams of fiber per serving, for example, to encourage them to read food labels and choose healthy snacks. Parents can also assist in making shopping entertaining for children by encouraging them to read food labels. There are many enjoyable, engaging adapted sports that children may participate in; doing so will ensure they have a nice time while getting a decent cardiovascular workout. Children should be encouraged to select an activity they enjoy and feel secure performing.

A child who participates in group exercise will also overcome the issue of social isolation and establish new acquaintances outside of their peer group. Exercise will also keep children away from electronics and television, which is a worry for children everywhere. Children between the ages of eight and 18 spend more than seven hours a day using technology; given this, it is surprising that obesity affects children of all ages, whether or not they have special needs. For parents of underweight children who do not have a voracious appetite, experimentation, trying out a variety of foods that are most likely to irritate the palate and offer sufficient nutrition, is typically the first step. Supplementing a child's diet with vitamins can be a great option if your efforts are not yielding the desired results. It is crucial to go deeper and determine whether a child's lack of appetite could be related to a more serious condition like depression. This illness is marked by a lack of enthusiasm for past interests and pastimes, a lack of energy, and a desire to avoid social situations and contacts. A psychologist or psychiatrist should be seen if depression is suspected; they can provide effective treatments such as cognitive behavioral therapy, medication, or a combination of the two.

The significance of a suitable supplement may once more be relevant for a child with special needs who has allergies to a specific type of food or a child who refuses to consume products that are not on a predetermined list of meals. Many parents claim that just getting their child to eat anything at all is a major accomplishment, which should serve as a reminder that nutrition should be treated

gradually and that every small victory is to be fully acknowledged (Doyle, 2020). Additionally, overcoming the main dietary obstacles faced by children with special needs is a complicated problem that is occasionally within and outside of a parent's control. However, it is crucial to do everything in our power to ensure that children with special needs are able to enjoy the vibrant, flavourful, and richly textured world of healthy food, for both sport and daily life.

Children with special needs do not need any additional care when treating moderate acute diarrhea. A strict clear liquid diet is no longer the preferred course of treatment, but enough fluid intake should still be a top focus. According to recent research, the majority of instances of acute diarrhea can be treated with feeding using a regular diet (Vanderhoof, Murray, Paule & Ostrom, 2007; Kleinman, 2019). Breastfeeding should be continued on demand for a child with a disability, and additional fluids should be given if necessary for supplementation. The gastrointestinal mucosa may be stimulated and protected by chemicals found in breast milk (Nazarian, 2016). Children's nutritional formula should be added to their regular formula. In the past, people with diarrhea have traditionally avoided milk and formulas based on milk. During the disease, mucosal injury could result in transient lactase insufficiency. However, at least 80% of children with this transitory lactase shortage do not experience worsening diarrhea and can continue to drink milk or formula without risk (Duggan & Nurko, 2017). Only in cases where stool production on a milk-based formula increases is switching to a lactose-free formula advised. A period of "bowel rest" with only clear liquids, followed by a gradual reintroduction of first diluted, then full-strength formula or milk, along with a very restricted diet of solid foods, were the previous recommendations for treating acute diarrhea. No longer advised is diluted formula. Recent studies have shown that starting a routine diet earlier results in a superior overall result. Decreased length of illness, improved weight gain, and improved nutritional status are specific positive outcomes (Meyers, 2005; Duggan & Nurko, 2017).

Additionally, prior to creating a successful solution, it is always important to comprehend the factors that contribute to the emergence and persistence of challenging behaviours. When a child actively, verbally, and repeatedly rejects food, behaviourists, social workers, or counselors are frequently consulted by the feeding team. This behaviour could be accompanied by tantrums and hostility. It is quite late in the formation of the behavioural sequence, despite the fact that this is a perfect setting for applying behaviourist skills. Other experts can refer patients early in the unpleasant conditioning phase, ideally before the behaviour has a chance to develop at all, by knowing how food refusal develops. The interventions listed below could help with certain behavioural issues:

1. **Classical Conditioning:** According to classical conditioning, behaviors can be formed (learned) based on what takes place prior to or during the behaviour (Moore, 2012). When a neutral input is combined with another stimulus, classical conditioning takes place. Such conditioning happens during eating when food is introduced to the mouth together with

discomfort or satiety. The neutral stimulus transforms into a discriminative stimulus that will result in a punisher or reinforcer. A nipple in the mouth, for instance, can serve as an indication or warning that pain or satiation is about to strike.

2. **Operant Conditioning:** What happens after a behaviour can also condition future behaviour. Opportunistic conditioning is what this is. According to Malott and Trojan (2018), operant conditioning happens when a behaviour, such as sucking, is followed by a response, such as pain or satiation, which either rewards or reinforces the behaviour. A predictable response that either rewards or punishes the occurrence of a behaviour follows it. For instance, the discomfort or satiation caused by sucking rises or diminishes in the future. If a behaviour appears more frequently in the future, it has been reinforced. If it does so in the future less frequently, it has been penalized. Even an apparent positive response, like presenting a bottle, might be a punishment if it results in a negative reaction, like discomfort, which makes the activity less likely to occur again.

When a youngster identifies a painful or unpleasant event with a feeding stimulus that is neutral, aversive conditioning in eating takes place. Medical, physical, sensory, or environmental stressors might cause this unpleasant conditioning to occur. For instance, discomfort is there concurrently (operant) anytime the nipple is offered. Although reflux, not the nipple, actually causes the pain, the nipple ends up symbolizing it. This conditioned response eventually leads to avoidance behaviors like arching your back to reject the nipple. The pain is not lessened by refusing the nipple, but it is (classical) by arching. This hypothetical situation illustrates a fusion of classical and operant conditioning.

3. **Environmental Reinforcement:** While a child's initial food selectivity and refusal are frequently due to physical, physiological, or sensory factors, what happens in the environment as a result of that food refusal is as essential. According to Cooper, Wacker, McComas, Brown, Peck, Richman, Drew, Frischmeyer, and Mill (2005), there are four environmental factors that frequently perpetuate both positive and bad behaviors. We may start to understand how these variables might be influencing behavior by studying what occurs right before and after meal acceptance and refusal:

a. Food aversion reinforced by attention;
b. Escape: the act of avoiding a disliked task;
c. Giving a child something or engaging in an activity when they avoid a feeding job they don't like is a tangible way to reinforce their unwillingness to eat.
d. Unobservable, non-environmentally based events that happen right after a feeding activity are known as internal reinforcers of food refusal.

A functional assessment is a data-driven strategy based on how the child responds to environmental influences. These elements can affect attention, escape, tangible objects, environmental structures, timing and pacing, people present, and

interior events like pain, among others. It is a systematic technique that determines what the child is attempting to accomplish through the behavior and bases the intervention on that knowledge. To meticulously track development, data is continuously collected, and changes are made in response to the data. Techniques are technically correct while being tailored to the family's requirements and capabilities. This strategy assumes that the primary caregivers are able and willing to implement suggestions. For the appropriate demographic, it is a targeted, budget-friendly strategy (Mueller, Piazza, Moore, Kelley, Bethke, Pruett, Oberdorff, & Layer, 2013). A functional assessment for dietary dysfunction must include taking a full history and completing a thorough developmental and sensory evaluation. Parents should be carefully listened to when they discuss how mealtimes are structured and how they vary from one another. To collect information on the observed behaviors and interactions, it is also important to monitor one or more feedings. We refer to this as an organized observation.

Summary and Recommendations

The difficulties in meeting the nutritional requirements of children with special needs are numerous and diverse. Groce, et al (2014), opines that the majority of children with special needs have problem swallowing food, spit out excessive amounts of saliva, frequently experience constipation, and occasionally have food fall from their mouths when being fed. For children with disabilities, flourishing and surviving can be very challenging tasks. Parenting a child with a disability presents a variety of difficulties (Hakime, 2013). Children with disabilities typically need extra care since they could have different demands than children without disabilities (Bhutta et al., 2013). It is possible that parents and other caregivers do not know the best ways to feed their child with disabilities or how to train him or her to feed themselves. This is crucial for children with disabilities like cerebral palsy, who may require particular seating or placement to manage muscle spasms, as well as children with Down syndrome, who have a higher risk of choking and contracting pneumonia. Insufficient food intake may occur as a result of stressful mealtimes for both the caregiver and the child (Hesketh & Pring, 2012). As a result, the child may receive less food since feeding a child with poor muscle tone and spasticity takes a lot of time, and no one in the home has the energy or time to do it. These discussions led to the following recommendations:

1. It is important to give children with disabilities a healthy food and nutrients;
2. To meet their nutritional needs, children with impairments should get a variety of foods every day;
3. Children with disabilities should receive additional time for feeding from parents and carers;
4. To make sure that they get the recommended daily dietary needs, feeding assistance for children with impairments is recommended.

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