Feeding and Eating in Early Intervention: A Trust-Based Approach

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Mealtimes are for...

Positive tilt = Parent and little one leaning into each other

Mealtimes should feel good!

The Feeding Relationship by Ellyn Satter
Zero to Three article

“Feeding is a reciprocal process that depends on the abilities and characteristics of both the parent and the child.

The child indicates an interest in being fed, with more or less clarity, and the parent responds to that interest readily, reluctantly, or not at all.”

Feeding development should be considered transactional or bi-directional, in context of a long-term relationship between parent and child. (Walton, Kuczinski, Haycraft et al., 2017)

Mealtimes occur...
- 8-12 times/day for infants
- 5-8 times/day for toddlers

Responsive Parenting → Responsive Feeding
- Prompt: Respond promptly to cues of hunger and satiety
- Emotionally Supportive: No pressure, focus on learning and love, feed patiently and slowly
- Contingent: Acknowledge the child's communication, if child struggles, experiment with different combinations, tastes, textures...
- Developmentally Appropriate: Support self-feeding, make passive mealtime behaviors, expose to new foods, tastes, textures

Responsive Feeding is Embedded in the Theoretical Framework of Responsive Parenting
- Responsive behaviors are:
  - prompt
  - emotionally supportive
  - contingent
  - developmentally appropriate

Responsive Feeding: Guiding Principles for Complementary Feeding of the Breastfed Child
- Feed infants directly and assist older children when they feed themselves, being sensitive to their hunger and satiety cues.
- Feed slowly and patiently, and encourage children to eat, but do not force them.
- Minimize distractions during meals if the child loses interest easily.
- Remember that feeding times are periods of learning and love - talk to children during feeding, with eye contact instead.
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**Pediatric Feeding Disorder (PFD)**

“Impaired oral intake that is not age-appropriate, and is associated with medical, nutritional, feeding skill, and/or psychosocial dysfunction.”

Goday et al., 2019

**Pediatric Feeding Disorder (PFD) may occur with:**

- Prematurity
- Poor growth
- Chromosomal abnormalities
- Syndromes
- Disease/Disorders
- Neurological problems
- Dysphagia
- Allergy or intolerance

**Definition**

Pediatric Feeding Disorder (PFD)

- Prevalence between 33% to 80% in children who have developmental disorders, incidence increasing (Lefton-Greif, 2008)
- Incidence increasing (Lefton-Greif, 2008)

- For these infants and children, every bite of food can be painful, scary, or impossible, potentially impeding nutrition, development, growth, and overall well-being (www.feedingmatters.org)

**Breastfeeding is Responsive Feeding**

- Babies who are fed responsively are more likely to continue being breastfeed
- Breastfeeding was associated with lower levels of control compared to formula feeding (Brown & Lee, 2013)
- Parent-led routine for infant feeding may discourage breastfeeding; encouraging a baby to feed to a parent-led routine rather than its own natural patterns may promote obesity
- The association between maternal anxiety and formula use has been well established. (Brown & Arnott, 2014)
- Please seek out education, can and should happen through EI

**Cue-Based Feeding in the NICU: Using the Infant’s Communication as a Guide**

- Focus of feeding is on experience not on “getting it all in”
- Infants gain physiologic stability
- Infants gain enhanced self-regulation and coping skills

(Shaker, 2013)
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Reading the Feeding

Catherine Shaker
ASHA Leader, 2013

Feeding

- The infant behaves certain ways during feeding for a reason.
- Volume-driven responses to physiologic instability may create a pattern of stress and feeding refusal behaviors.
- Focusing on emptying the bottle, or defining an empty bottle as success, may alter the preterm infant’s feeding experience and adversely affect neuromaturation and feeding outcomes.
- If each feeding is as stress-free as possible, however, the infant learns to respond positively to feeding.

Controlling Feeding

"Controlling feeding may arise when children experience problems in feeding or growth, such as recovery feeding after illness. Under these circumstances, recommendations tend to be guided by a child’s nutritional needs, focusing on the quantity and quality of food and the frequency of feeding. As a result, health and nutrition counselors may not focus on parent responsivity and parents may interpret the recommendations as a mandate to use controlling strategies to “get their child to eat.” This strategy has the potential to undermine the child’s trust in an otherwise responsive parent."

(Black & Aboud, 2011)

Feeding Problems and Mealtime Dynamics

- Medical/feeding hx:
  - Milk and soy protein intolerances in infancy
  - Gagged and coughed with early introduction of solids
  - Diet slowly expanded with therapist and sitter

- Mealtime Dynamics:
  - B still would not eat well with her parents
  - Parents would offer separate meal for B
  - Parents would prepare additional foods as B requested at meals
  - Parents prompted and tried to convince B to try new foods

Case Study: B

SATTER Division of Responsibility

Feeding Problems

Conflict
Increased attempts to control
Decreased sharing of pleasure

(Aviram, 2014)

The Worry Cycle

1. Recommendations:
   - Parents coached to serve food family style, including 1 of B’s favorites at each meal
   - Encouraged B to serve others
   - Parents modeled positive mealtime behavior
   - Parents stopped prompting

2. Outcomes:
   - Family meals more pleasant
   - Parents felt less stress
   - B seemed more relaxed at mealtimes and tried new foods
Impact of feeding problems on relationships

Maternal stress related to mothers’ own sense of competence

Patern stress is more related to child temperament and individual characteristics
(Aviram et al., 2014)

Impact of feeding problems on relationships

• Feeding relationship and bonding (Satter, 1995)
• "The lack of a feeding relationship disturbs the development of maternal identity, and the loss of oral feedings can be assumed to have a traumatic impact." (Wilken, 2012)

Impact of feeding problems on relationships

Affects interactions within the family unit

Extends beyond mealtimes
(Lucarelli et al. 2017)

Discussion

Trauma

Individual trauma results from an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or life-threatening with lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.

http://www.integration.samhsa.gov/clinical-practice/trauma
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*ACES STUDY*

ACES:
- Physical Emotional or Sexual abuse
- Physical or Emotional neglect
- Parental mental illness
- Substance dependence
- Incarceration
- Parental separation
- Domestic violence

*Parents*

- Grief
- Impatience
- Frustration
- Failure
- Confusion

*Establishing Relationships and Building Trust*

Parents must be heard and included
Parents need support
Do not feel heard by healthcare professionals

63% reported that healthcare providers did not address their concerns in a sample of 300 parents (Zucker, 2015).
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Understanding the Family's Experience

- Kids are often unable to eat with family
- Feel guilt over child's diet
- Concern of child's nutrition

- Don't understand their child's logic
- Lack of social support
- May not be supported by physician
- May feel isolation

(Klein, 2015)

Parent Solutions: What's working for NOW

Parents may have tried a variety of different things to help:
- Offer same foods in the same way
- Feed child separately
- No eating out
- Use of screens or other distractions

(Klein, 2015)

What Do We Judge?

- Breastfeeding vs. bottlefeeding
- Cultural feeding practices
- Homemade vs. storebought baby food
- Organic vs. non-organic
- Homemade blend vs. formula (tube-fed kids)
- Mealtime expectations for toddlers
  - Mess at mealtimes
  - Manners

ALTERNATIVE Language we use to describe children:

- AVERSION
- FOOD REFUSAL
- DELAYED
- HYPERSENSITIVE
- "BEHAVIORAL"

Judgement and Bias

How do we assess and describe...
- Children?
- A child's eating patterns?
- Foods?
- Parents/Caregivers?

Judgement

Noun
1. an act or instance of judging.
2. the ability to judge, make a decision, or form an opinion objectively, authoritatively, and wisely, especially in matters affecting actions; good sense; discretion: a man of sound judgment.
3. the demonstration or exercise of such ability or capacity: The mayor was decorated for the judgment he showed under fire.
4. the forming of opinion, estimate, notion, or conclusion, as from circumstances presented to the mind: Our judgment as to the cause of his failure must rest on the evidence.
5. the opinion formed: He regretted his hasty judgment.

(Judgment)
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Conversations with Parents

Early Intervention Guidelines

“SLPs in EI may provide services for children with feeding/swallowing deficits related to sensory integration, medically stable oropharyngeal disorders and behavioral issues only.

All other feeding/swallowing deficits are medically related and should be referred to the child’s primary medical physician or medical home for medical intervention.”

Questions so far?

Mission and Key Principles

Part C early intervention builds upon and provides supports and resources to assist family members and caregivers to enhance children’s learning and development through everyday learning opportunities.

Evaluation/Assessment
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Before Assessment Day

Who’s on the Team?

- FAMILY
- Extended family members
- Pediatrician
- Service coordinator
- Social worker
- Registered dietitian
- Speech-Language pathologist
- Occupational therapist
- Child care educator
- Gastroenterologist
- Allergist
- ENT
- Pulmonologist
- IBCLC
- Nurse
- Psychologist

Review Paperwork

Medical history
- Birth history
- Diagnoses
- History of medical procedures
- Hospitalizations, significant illnesses
- Past and present assessments and/or therapies
- Medications
- Psychosocial history

Who Should be Present at Initial Eval/Assess?

- Avoid “this is how we always do it”
- What is best for this family?
- The family should know their options
- Evaluators should have specialized expertise
- Best practice is a multidisciplinary perspective

Prepare the Parent

- Build Rapport BEFORE the visit
- Listen to parent concerns
- Explain what will happen
- Converse feeding feedback
- Ask parent to bring familiar foods, utensils, etc.
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Assessment

Parent Interview

Medical History

Feeding History
- Describe early feeding experiences:
  - Bottle fed or breast fed?
  - Formula? What kind?
  - Breast milk, via breast or bottle?
  - Nac or bottle?
  - When were solids introduced?
  - Were there any difficulties with transition to solids?
- How did early feeding experiences feel for the parent?
- How did any complications influence the child’s ability to eat?

Current Status
- Current diet/food repertoire
- Report of mealtime structure and routine
- Any special preparation or modification of food that is required
- Utensils and vessels used
- Typical quantity of intake
- Coughing, gagging, protective responses
- Behavioral responses during mealtimes
- Family and mealtime dynamics

Pre-feeding Skills Checklist
Morris & Klein, 2000

- Review information from paperwork
- Gauge parent(s)/child’s understanding of child’s diagnoses, medical procedures, test results
- Family history of feeding problems, allergies, other illnesses
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Pre-Feeding Skills Checklist
Morris & Klein, 2000

Feeding Observation
Round the parent of what will happen next
Parent as Primary Feeder
Parent feeds as they would
Observe and make suggestions if warranted

Observe:
• How is the child positioned?
• What is the environment?
• What foods are offered?
• What is the child’s reaction to the food?
• What is working best?
• What are the challenges?

*Ask if this meal resembles typical mealtimes.

Feeding Observation: Mealtime Dynamics
Is the parent reading the child’s nonverbal cues?
How does parent respond to successes/difficulties?
Is distraction used?
Is the child engaged?
Does the child help with the feeding?
Does the child seem happy?
Is the pacing appropriate?

Oral-Motor Exam

- Symmetry and formation of oral structures
- Oral and facial muscle tone
- Breathing patterns
- Resting mouth position
- Oral sensory function
- Vocal quality
- Oral motor planning
- Strength, range of motion, and coordination of facial, jaw, tongue, and orofacial musculature
Feeding Observation: Assess Foods Offered

- Taste
- Texture
- Variation

Feeding Observation: Assess Skills

- Breastfeeding
- Bottle drinking
- Cup drinking
- Straw use
- Utensil use
- Oral preparation/swallowing

What is working?

- Where is the child receiving their primary source of nutrition?
- What seems to be the “easiest”/most natural for the child?
- When does the child lean in?

(Morris & Klein, 2000)

Feeding Observation: Understanding the Dyad

Avoid making assumptions
- Ask parents questions:
  - I’m noticing that…What do you think this means?
  - What has worked in the past?

Areas of Need

Describe what may be contributing to feeding difficulty
- Narrate what is happening
- It looks like____________

Problem-Solving Together

Allow parent to lead/endorse
- What if they try____________?
- What do you think would happen if______?

Make gentle adjustments and ask questions
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Communication

“I’m noticing that _________.”

“What would happen if _________.”

“Could we try _________?”

“What would you think about _________?”

“Would it be okay if _________?”

Report Writing

• Use parent-friendly language
• If necessary, have report translated
• Avoid jargon
  • Use professional language
  • Define professional language
• Describe what happened (don’t use value-based terminology)
  • Jack refused his mother’s presentation of the spoon.
  • Jack turned his head away when his mother presented the spoon.

Making a Plan

Check-in: parent’s emotional state
Make sure the parent knows what to do, and have them try strategies/practice what you’ve demonstrated
Find out what is important to them. Out of everything we’ve tried today, what was the most useful to you?

Create outcomes together
Are there other professionals or resources that would be helpful?

Outcomes and Strategies

Making a Plan

Ensure that parent understands recommendations in the context of development
Written recommendations
Make sure parent understands what will happen next

Key Principle #4 (NE):
The early intervention process, from initial contacts through transition, must be dynamic and individualized to reflect the child’s and family members’ preferences, learning styles and cultural beliefs.

http://www.nectac.org/~pdfs/topics/families/Principles_LooksLike_DoesntLookLike3_11_08.pdf
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Key Principle #5 (NE): IFSP outcomes must be functional and based on children’s and families’ needs and priorities.

Developing Outcomes

Parents are:
• more invested in reaching goals
• more satisfied with services
• more hopeful about managing life

Outcome Writing: Parents as Partners

Recommendations: Caregiver Considerations

Emotional resources (anxiety, depression, stress)
Financial resources
Time
Outside support (mental health, family, community)
Cognitive ability
Cultural practices
Personal history

High quality IFSP functional outcomes:
✓ are necessary and functional for the child’s and family’s life
✓ reflect real-life contexts/settings (mealtime routines)
✓ integrate developmental domains and are discipline-free
✓ are jargon-free, clear, and simple
✓ emphasize the positive, not the negative
✓ use active rather than passive words

Sample Outcomes

Parents as Partners

Jose will be able to drink comfortably and efficiently from the bottle so he can grow well.

Kate will eat a variety of table foods and be able to drink liquids from a cup so that she can participate in family mealtimes.
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What EI or other supports are available?

Consider more than one discipline
- Speech
- Occupational therapy
- Physical therapy
- Social work
- Nutrition
- Include physicians and specialists outside of EI
- Assistive technology

Treatment

Feeding issues are complicated.

Children need to FEEL GOOD before they can eat.

Treatment

Use Development As a Guide

Gross motor
Fine motor
Cognitive
Communication
Feeding skills

Start with What is Working

FAMILIAR

Key Principle #2 (EI)

The focus of EI is to encourage the active participation of families in the therapeutic process by embedding intervention strategies into family routines.

It is the parents who provide the real early intervention by creatively adapting their child care methods to facilitate the development of their child, while balancing the needs of the rest of their family.

(Morris & Klein, 2000)
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Parent Coaching

Responsive Feeding Strategies: Supporting Development of Trust Between Child and Caregiver
- Educate all caregivers
- Online observations
- Ask parent to interpret behavior
- Video review

Help Caregivers Learn a Child’s Cues

Making Changes
- What worked today?
- Offer a few options for integrating new strategies into routines
- Parent helps choose what to implement next
- Give the parent a “game plan” for every mealtime

Communication
- “I’m noticing that ________”
- “What would happen if ________?”
- “Could we try ________?”
- “What would you think about ________?”
- “Would it be okay if ________?”

Continuum of Options

Child Motivated
- Self-feeding

Adult Motivated
- Force feeding

(Klein, 2012)
JAL [2]9 I left this "left block" black to match the earlier slide (101) and 
reactivate prior knowledge
Jones, Alissa Leigh, 6/5/2019
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### Child-Led, Relationship-Based, Trust-Based Approaches
- Get Permission Approach (Klein)
- Sequential Oral Sensory Approach (Toomey)
- Mealtime Partners (Suzanne Evans Morris)
- SOFFI Method (Ross)
- Food Chaining (Fraker & Fishbein)
- STEPS Approach (McGlothlin & Rowell)

### Building Trust:
- Educate parents about typical infant and toddler feeding development patterns
- Develop appropriate expectations
- Start with “what’s working”
- Ongoing discussion of the child’s strengths and areas of need, parent’s changing goals

### Building Trust: Caregiver Considerations
- Emotional resources (anxiety, depression, stress)
- Financial resources
- Time
- Outside support (mental health, family, community)
- Cognitive ability
- Cultural practices
- Personal history

### Cultural Considerations
- **Cultural responsiveness** is about reciprocity and mutuality. The process involves exploring differences, being open to valuing clients’ knowledge and expertise, and recognizing the unique cultural identity of each individual client (Munoz, 2007).
- When cultural considerations are addressed, outcomes are better (Davis-McFarland, 2008)

### Behavioral Modification Strategies
- Arvedson, Brodky, Lefton-Greif, 2020

Building Trust with Families
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Barriers to Communication with Parents

- Parent stress/mental health
- Misunderstanding of therapeutic relationship
- Misunderstandings regarding individual/personal factors
- Practitioner judgement/bias
- Practitioner difficulty grading communication

Questions so far?

Teaming and Collaboration

Key Principle #3 (EI)

EI requires a collaborative relationship between families and providers, with equal participation by all those involved in the process.

An on-going parent-professional dialogue is needed to develop implement, monitor, and modify therapeutic activities.

Avoid Judgment

- Make intentional language choices
- Consider questions we ask and how we ask them (e.g., “How did things go this week? What did you try?”)
- Anna’s mom- “I almost didn’t want you to come today because I haven’t done any feeding and I should be doing more. I need to do more.”

How do we contribute to this?

How can we avoid contributing to this?
Team Collaboration & Communication

All team members are aware of the plan and parent is supported throughout the week. Use IFSP development time wisely (includes consultation with physicians identified on the IFSP). Connect with team members outside of EI.

Teaming and Collaboration

Can you think of a time when you collaborated with another member of the team in a way that benefitted the family?

12 Families with children with “FTT” diagnosis

One third of families (4 families) felt as if they were part of the team.

Almost all families described:

- Feeling helpless
- Not feeling heard
- Feeling blamed for their child’s diagnosis
- Feeling isolated

(Thomlinson, 2002)

Teaming and Collaboration

Families felt part of the team when medical professionals:

- Accepted their assessment of the child’s condition
- Listened to them

(Thomlinson, 2002)
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Teaming and Collaboration

A multidisciplinary team can holistically address a child’s health and well-being:
- Medical management
- Sensorimotor skill building
- Behavioral support
- Hunger provocation
- Pain management
- Sensory integration difficulties

(Edwards et al., 2015)

Case Study: Spencer

- At four months Spencer’s parents noticed motor delay
- Low tone
- Started working with Spencer at 18 months
- Non-verbal
- Not growing well
- Feeding skills
- No self-feeding
- Was refusing spoon feeding from parent
- Was bottle drinking
- Was not self-feeding

Key Principle #7 (NE):
Interventions with young children and family members must be based on explicit principles, validated practices, best available research and relevant laws and regulations.

Resources

- American Speech-Language Hearing Association: www.asha.org
- Cadence: Shaker Swallowing and Feeding Seminars: www.shaker4swallowingandfeeding.com
- Chicago Feeding Group: http://www.chicagofeedinggroup.org/
- DEC Recommended Practices: https://divisionearlychildhood.egnyte.com/dl/tgv6GUXhVo
- Dysphagia Resource Center: www.dysphagia.com
- Expert Feeding Help for Parents and Professionals (Melanie Potock): www.mymunchbug.com
- Feeding Flock assessment tools: https://www.feedingflock.com/tools
- Feeding Flock: https://www.feedingflock.com/
- Feeding Matters: www.feedingmatters.org
- Frequently Asked Questions (FAQs) SLP Provider Information Notice (04/19/11): http://www.wiu.edu/ProviderConnections/policy/EIProviderUpdate.php?id=172
- Mealtime Notions (Klein): www.mealtimenotions.com
- New Visions (from Suzanne Evans Morris, Ph.D.): www.newvisions.com
- Pediatric Feeding News (Krisi Brackett): http://pediatricfeedingnews.com/
- Principles of Early Intervention: https://education.illinois.edu/principles.html
- The Feeding Relationship, by Ellyn Satter: https://www.zerotothree.org/resources/1071-the‐feeding‐relationship

Resources

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(Edwards et al., 2015)
I noticed some resources or references were listed twice so I omitted them. I put titles in front of the links that were originally just links and alphabetized.
Recommended Reading

- Pediatric Feeding and Dysphagia: Assessment and Management by Linda Arvedson, OTR
- The Feeding Skills: A Comprehensive Resource for Infants and Toddlers by Linda Arvedson, OTR
- How to Get Your Toddler to Eat (And Not Fight Meals) by Rhys Baker, RD, CD, CDE
- Helping Your Child with Extreme Pfizer Eating by Joanne Kershaw, MD, Jovita Meiklejohn, RD, CD, CDE
- Baby Eating by Nancy Rollin & Melanie Potter

Check the EC Learning Library for these https://eclearinghouse.org

Selected References