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

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Mealtimes are for…

2

Mealtimes should feel good!

Positive tilt = Parent and little one leaning into each other

(Klein, 2015)

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Feeding and Relationships

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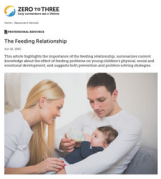
The Feeding Relationship by Ellyn Satter Zero to Three article



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Feeding and Relationships

"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."

- Ellyn Satter, *The Feeding Relationship*, www.zerotothree.org, 1992

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Mealtimes Occur…

8-12 times/day for infants

5-8 times/day for toddlers

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Responsive Feeding is Embedded in the Theoretical Framework of Responsive Parenting

Black & Aboud, 2011

- Responsive behaviors are:
  - **prompt**
  - **emotionally supportive**
  - **contingent**
  - **developmentally appropriate**

(Black & Aboud, 2011)

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American Academy of Pediatrics and Responsive Feeding

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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	Model positive mealtime behaviors	Expose to new foods, tastes, textures

(Black & Aboud, 2011)

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Responsive Feeding

GUIDING PRINCIPLES FOR COMPLEMENTARY FEEDING OF THE BREASTFED CHILD, PAHO/WHO, 2003

- 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;
- If children refuse many foods, **experiment** with different food combinations, tastes, textures and methods of encouragement;
- **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 to eye contact

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Definition

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

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Pediatric Feeding Disorder (PFD)

- Prevalence between 33% to 80% in children who have developmental disorders, 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)

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Pediatric Feeding Disorder (PFD) may occur with:

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

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Pediatric Feeding Disorder (PFD) may occur with:

- Developmental experiences or lack thereof
- Environmental challenges
- Sensory processing difficulties
- Mental Health
- Poor Attachment
- Trauma

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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

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

When pre-term infants are fed using cue-based practices:

- 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

- 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.

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SATTER Division of Responsibility

Case Study: B

- 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

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SATTER Division of Responsibility

Case Study: B

- 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
- Outcomes:
  - Family meals more pleasant
  - Parents felt less stress
  - B seemed more relaxed at mealtimes and tried new foods

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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 children'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)

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Feeding Problems and Mealtime Dynamics

Feeding Problems

Conflict

Increased attempts to control

Decreased sharing of pleasure

(Aviram, 2014)

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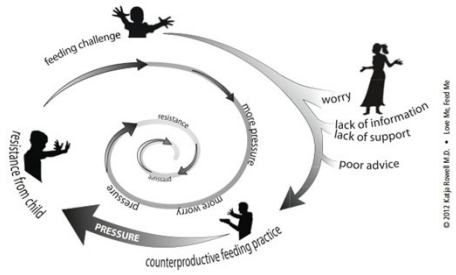
The Worry Cycle



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Impact of feeding problems on relationships

Maternal stress related to mothers' own sense of competence

Paternal stress is more related to child temperament and individual characteristics

(Aviram et al., 2014)

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Discussion

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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)

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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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Trauma

Acute OR Chronic

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Trauma

ACES STUDY

ACES:

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

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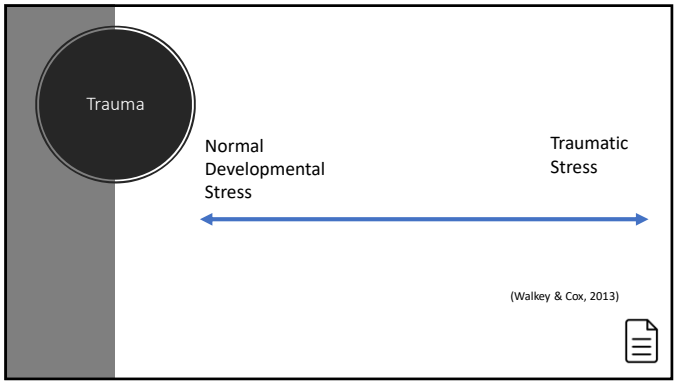

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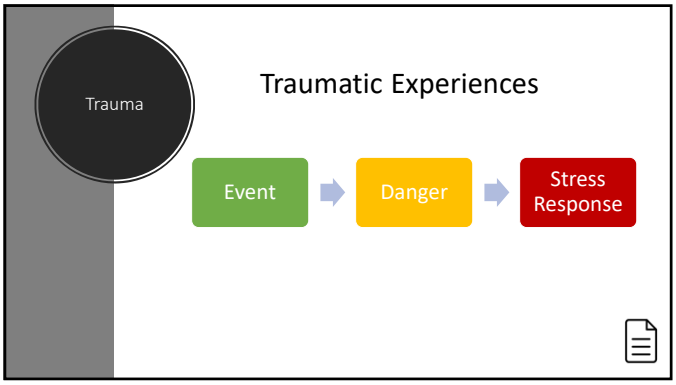

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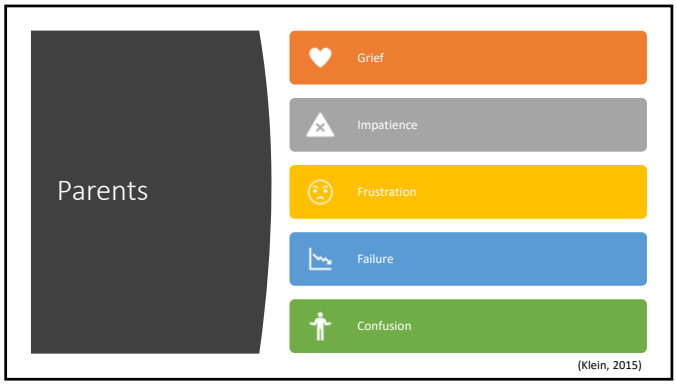

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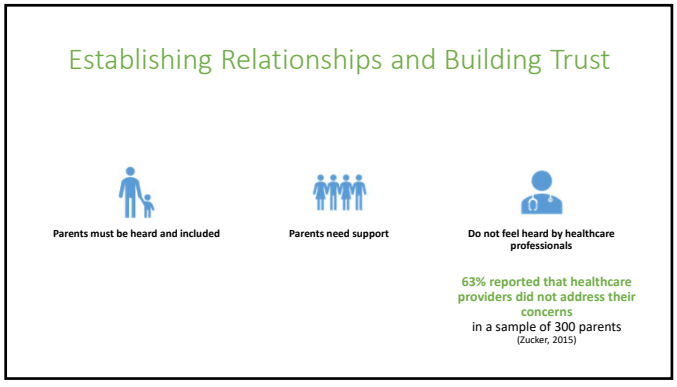

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Parent Solutions: What's working for NOW

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)

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Judgement and Bias

How do we assess and describe…

- Children?
- A child's eating patterns?
- Foods?
- Parents/Caregivers?

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Judgment

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 action; good sense; discretion: *a man of sound judgment.*
3. the demonstration or exercise of such ability or capacity: *The major 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.*

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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

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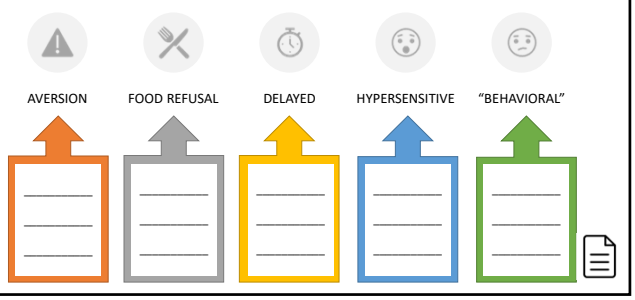
ALTERNATIVE Language we use to describe children:



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Conversations with Parents

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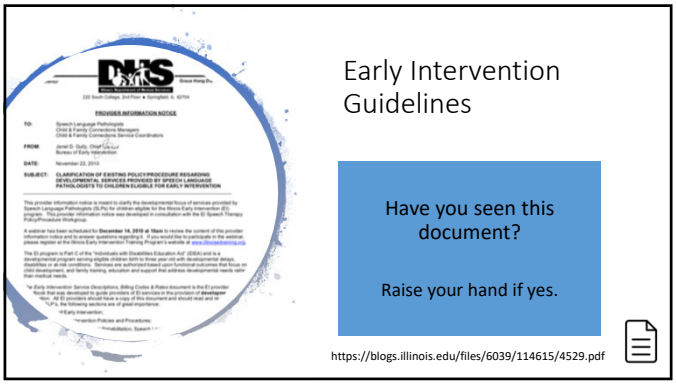

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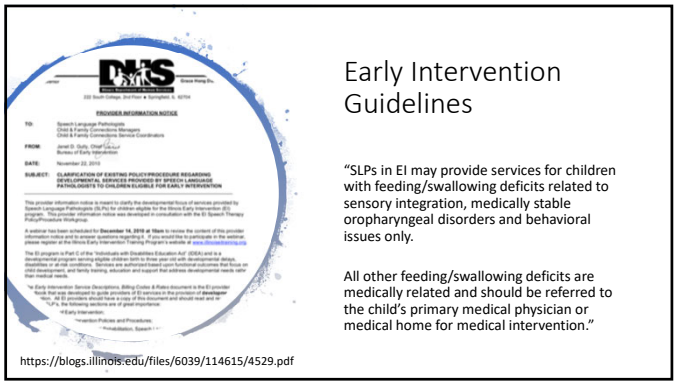

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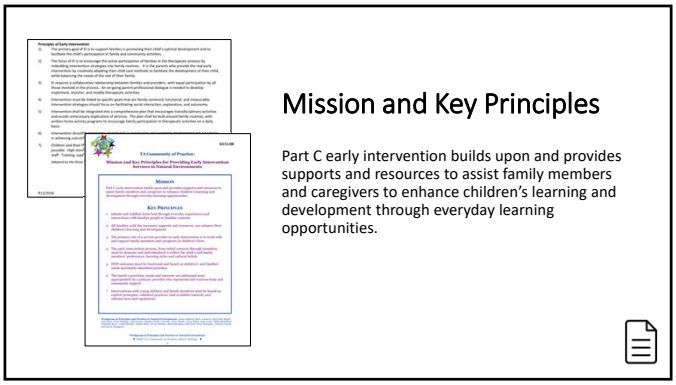

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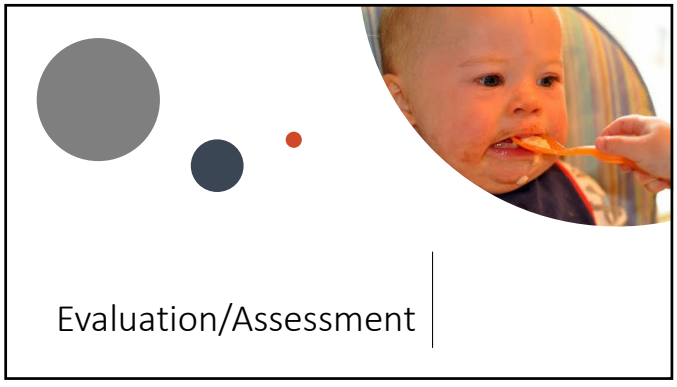

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Review Paperwork

Medical history

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

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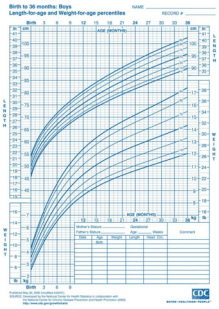
Review Paperwork

Review Growth



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Who's on the Team?

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

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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

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Prepare the Parent


Build Rapport BEFORE the visit


Listen to parent concerns


Explain what will happen

Conversation
Feeding
Feedback


Ask parent to bring familiar foods, utensils, etc.

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Assessment

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Parent Interview

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Medical History

- Review information from paperwork
- Gauge parent(s)'s understanding of child's diagnoses, medical procedures, test results
- Family history of feeding problems, allergies, other illnesses

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Feeding History

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

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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

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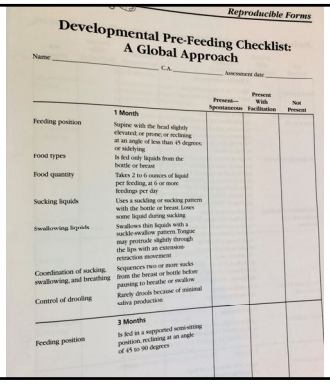
Pre-Feeding Skills Checklist

Morris & Klein, 2000



Reproducible Forms

Developmental Pre-Feeding Checklist: A Global Approach

Name _____ C.A. _____ Assessment date _____

	1 Month	Present—Spontaneous	Present With Facilitation	Not Present
Feeding position	Supine with the head slightly elevated; or prone; or reclining at an angle of less than 45 degrees; or sidelying			
Food types	Is fed only liquids from the bottle or breast			
Food quantity	Takes 2 to 6 ounces of liquid per feeding, at 6 or more feedings per day			
Sucking liquids	Uses a sucking or sucking pattern with the bottle or breast. Loses some liquid during sucking			
Swallowing liquids	Swallows thin liquids with a suckle-swallow pattern. Tongue may protrude slightly through the lips with an extension-retraction movement			
Coordination of sucking, swallowing, and breathing	Sequences two or more sucks from the breast or bottle before pausing to breathe or swallow			
Control of drooling	Rarely drools because of minimal saliva production			
	3 Months			
Feeding position	Is fed in a supported semi-sitting position, reclining at an angle of 45 to 90 degrees			

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Feeding Observation

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Oral-Motor Exam

Symmetry and formation of oral structures	Oral and facial muscle tone	Resting mouth position	Breathing patterns
Strength, range of motion, and coordination of facial, jaw, lip, and tongue musculature	Oral sensory function	Vocal quality	Oral motor planning

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Feeding Observation

- REMIND THE PARENT OF WHAT WILL HAPPEN NEXT
- PARENT AS PRIMARY FEEDER
- PARENT FEEDS AS HE/SHE TYPICALLY WOULD
- OBSERVE AND MAKE SUGGESTIONS IF WARRANTED

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Feeding Observation

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.

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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?

(Klein, 2015)

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Feeding Observation: Assess Foods Offered

- Taste
- Texture
- Variation

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Feeding Observation: Assess Skills

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

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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?

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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)

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Areas of Need

Describe what may be contributing to feeding difficulty

- Narrate what is happening
- It looks like_____.

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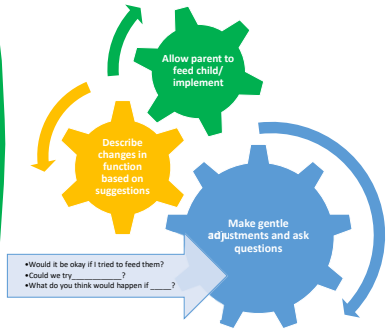
Problem-Solving Together



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AL [2]10

Communication

- "I'm noticing that _____."
- "What would happen if _____."
- "Could we try_____?"
- "What would you think about_____?"
- "Would it be okay if _____?"

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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 if 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?

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Slide 71

JAL [2]10 Jones, Alissa Leigh, 6/5/2019

Making a Plan

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

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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.

Handout, pg. 24

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Outcomes and Strategies

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Developing Outcomes

Key Principle #4 (NE)

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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Developing Outcomes

Key Principle #5 (NE)

Key Principle #5 (NE):
IFSP outcomes must be **functional** and based on children's and families' **needs and priorities.**

http://www.nectac.org/~pdfs/topics/families/Principles_LooksLike_DoesntLookLike3_11_08.pdf

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Outcome Writing: Parents as Partners

Parents are:

- more invested in reaching goals
- more satisfied with services
- more hopeful about managing life

(SAMHSA: Concept of Trauma and Guidance for a Trauma-Informed Approach, NTCSN)

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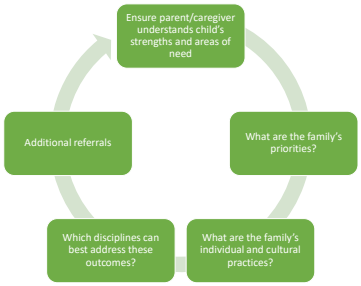
Outcome Writing : Parents as Partners



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Recommendations: Caregiver Considerations

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

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Sample Outcomes

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

From IL EI Provider handbook

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Sample Outcomes

- _____ so he can participate in mealtime routines with his family.
- 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

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Treatment

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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.

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Treatment

Feeding issues are complicated.

Children need to FEEL GOOD before they can eat.

(Edwards et. al., 2015)

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Use Development As a Guide

- Gross motor
- Fine motor
- Cognitive
- Communication
- Feeding skills

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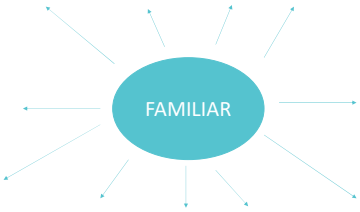
Start with What is Working



(Morris & Klein, 2000)

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Help Caregivers Learn a Child's Cues

- Educate all caregivers
- Online observations
- Ask parent to interpret behavior
- Video review

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AL [2]9

Communication

- "I'm noticing that _____."
- "What would happen if _____."
- "Could we try_____?"
- "What would you think about_____?"
- "Would it be okay if _____?"

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Responsive Feeding Strategies:

Supporting Development of Trust Between Child and Caregiver

- Modeling positive eating behavior at mealtimes (Harper, 1975)
- Encourage shared mealtimes
- No pressure (Galloway et al., 2006)
- Avoid using food as rewards for eating other foods (Finnanne et al, 2017)
- Respond promptly to child's cues of hunger and satiety (Black & Aboud 2011)

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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

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Continuum of Options

Child Motivated — Adult Motivated

Self-feeding — Force feeding

(Klein, 2012)

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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)

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Behavioral Modification Strategies

Table 13-2. Behavioral Treatment Strategies

Goal	Treatment Strategy	Examples
Increase desirable feeding behaviors	Positive reinforcement	Praise for bite acceptance Reward with access to preferred food or toys
	Negative reinforcement	Providing a break following bite acceptance
	Structured feeding environment	Mealtime schedule Appropriate seating and utensils
	Stimulus fading	Start with small bite sizes and gradually increase the size as child is successful
Reduce unwanted feeding behaviors	Escape extinction	Maintaining bite presentation until child accepts bite
Strengthen primary feeder skills	Ignoring	Ignoring all inappropriate behavior to avoid reinforcing it
	Caregiver training	Gradually introduce the primary caregiver as the feeder while providing coaching on how to implement the individualized behavioral feeding treatment plan

Arvedson, Brodsky, Lefton-Greif, 2020

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Slide 91

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

Building Trust with Families

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Building Trust:

- **Education**: Educate parents about typical infant and toddler feeding development patterns
- **Expectations**: Develop appropriate expectations
- **Strengths**: Start with "what's working"
- **Ongoing**: Ongoing discussion of the child's strengths and areas of need, parent's changing goals

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Building Trust: Caregiver Considerations

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

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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)

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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

101

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."

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How do we contribute to this?

How can we avoid contributing to this?

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Questions so far?

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Teaming and Collaboration

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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.

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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

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Teaming and Collaboration

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Teaming and Collaboration: Discussion

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

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ISSUES AND INNOVATIONS IN NURSING PRACTICE

The lived experience of families of children who are failing to thrive

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The lived experience of families of children who are failing to thrive

Objective. This study was conducted to explore the experience of families of children who were failing to thrive. The aim of the study was not to generalize the findings but to generate a rich description of the phenomenon of living with children who were not growing as expected.

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Teaming and Collaboration

- **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)

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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)

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Case Study: Spencer

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

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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.

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Resources

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Resources

- American Speech-Language Hearing Association: www.asha.org
- Catherine Shaker Swallowing and Feeding Seminars: www.shaker4swallowingandfeeding.com
- Chicago Feeding Group: http://www.chicagofeedinggroup.org/
- Clarification of Existing Policy/Procedure Regarding Developmental Services Provided by Speech-Language Pathologists to Children Eligible for Early Intervention http://www.wiu.edu/ProviderConnections/pdf/InfoNoticeclarifyingSLPPolicyProcedures1122.pdf
- 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

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Resources

- Frequently Asked Questions (FAQs) SLP Provider Information Notice (04/19/11): http://www.wiu.edu/ProviderConnections/policy/EIProviderUpdate.php?id=172
- Helping Your Child with Extreme Picky Eating (Rowell & McGlothlin): www.extremepickyeating.com
- Mealtime Notions (Klein): www.mealtimenotions.com
- New Visions (from Suzanne Evans Morris, Ph.D.): www.new-vis.com
- PAHO/WHO Guiding Principles for Complementary Feeding of the Breastfed Child: https://www.who.int/nutrition/publications/guiding_principles_compfeeding_breastfed.pdf
- Pediatric Feeding News (Krisi Brackett): http://pediatricfeedingnews.com/
- Principles of Early Intervention: https://eitp.education.illinois.edu/principles.html
- Seven Key Principles: Looks Like / Doesn't Look Like from Workgroup on Principles and Practices in Natural Environments: http://www.nectac.org/~pdfs/topics/families/Principles_LooksLike_DoesntLookLike3_11_08.pdf
- *The Feeding Relationship*, by Ellyn Satter: https://www.zerotothree.org/resources/1071-the-feeding-relationship

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Resources: Listservs, Newsletters, or Groups

Dysphagia listserv (www.dysphagia.com)

ASHA Division 13 (listserv and newsletter) (https://www.asha.org/SIG/13/)

Pediatric Feeding and Dysphagia Newsletter (Krisi Brackett, SLP) (http://pediatricfeedingnews.com/)

FeeDR Pediatric Dysphagia Facebook group (https://www.facebook.com/groups/88445812069/)

The Chicago Feeding Group (www.chicagofeedinggroup.org)

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Recommended Reading

Pediatric Swallowing and Feeding: Assessment and Management by Joan Arvedson, Linda Brodsky

Pre-Feeding Skills: A Comprehensive Resource for Mealtime Development – 2nd edition by Suzanne Evans Morris, Ph.D., and Marsha Dunn Klein, M.Ed., OTR

How to Get Your Kid to Eat--But Not Too Much by Ellyn Satter RD, A.C.S.W.

Child of Mine: Feeding With Love and Good Sense by Ellyn Satter, RD, A.C.S.W.

Helping Your Child with Extreme Picky Eating by Katja Rowell, MD, Jenny McGlothlin, MS, CCC-SLP

Baby Self-Feeding, by Nancy Ripkin & Melanie Potock

Raising a Happy, Healthy Eater, by Melanie Potock

Check the EIC Lending Library for these https://eiclearinghouse.org

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JAL3 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
Jones, Alissa Leigh, 5/22/2019

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