Mealtimes are for...

Mealtimes should feel good!

Positive tilt = Parent and little one leaning into each other

(Klein, 2015)

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 and Eating in Early Intervention: A Trust Based Approach

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 Feeding is Embedded in the Theoretical Framework of Responsive Parenting
Black & Aboud, 2011

Responsive Parenting → Responsive Feeding

American Academy of Pediatrics and Responsive Feeding

Responsive Feeding
GUIDING PRINCIPLES FOR COMPLEMENTARY FEEDING OF THE BREASTFEEDED 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 new 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 eyes to eye contact.

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

Responsive Parenting

Black & Aboud, 2011
Feeding and Eating in Early Intervention: A Trust Based Approach

**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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**Prevalence**

- 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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**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**

- 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)
• 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.

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

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

“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)

(Aviram, 2014)
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)

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)

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

ACES STUDY

• Physical Emotional or Sexual abuse
• Physical or Emotional neglect
• Parental mental illness
• Substance dependence
• Incarceration
• Parental separation
• Domestic violence
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Establishing Relationships and Building Trust

Parents

- Grief
- Impatience
- Frustration
- Failure
- Confusion

(Klein, 2015)

Establishing Relationships and Building Trust

- 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)

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

63% reported that healthcare providers did not address their concerns in a sample of 300 parents (Klein, 2015)
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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)

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

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”

Conversations with Parents
Questions so far?

Early Intervention Guidelines

Have you seen this document?
Raise your hand if yes.

https://blogs.illinois.edu/files/6039/114615/4529.pdf

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.”

https://blogs.illinois.edu/files/6039/114615/4529.pdf

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/Accessment

Before Assessment Day
Feeding and Eating in Early Intervention: A Trust Based Approach

Review Paperwork

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

Review Paperwork

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

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
Give correct feeding feedback
Ask parent to bring familiar foods, utensils, etc.

Assessment
Parent Interview

Medical History

Feeding History

Current Status

Pre-Feeding Skills Checklist

Feeding Observation

- 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

- 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

- Describe early feeding experiences:
  - Bottle fed or breast fed?
  - Formula? What brand?
  - Breast milk, milk-based or lactose?
  - Mix it in milks?
  - When were solids introduced?
  - Were there any difficulties with transition to solid foods?
  - How did early feeding experiences feel for the parent?
  - Child?
  - How did any complications influence the child's ability to eat?

- 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
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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

Feeding Observation

- Rounding the parent of what will happen next
- Parent as primary feeder
- Parent feeds as they typically would
- Observe and make suggestions if warranted

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)

Feeding Observation: Assess Foods Offered

- Taste
- Texture
- Variation

Feeding Observation: Assess Skills

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

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)

Areas of Need

Describe what may be contributing to feeding difficulty
• Narrate what is happening
• It looks like__________.

Problem-Solving Together

Describe changes in function based on suggestions
Allow parent to feed child/ implement

Communication

“I’m noticing that__________.”
“What would happen if__________.”
“Could we try__________?”
“What would you think about__________?”
“Would it be okay if__________?”

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

(Mor minor & Klein, 2000)
Making a Plan

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

Outcomes and Strategies

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

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

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

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, 2010]
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Outcome Writing: Parents as Partners

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

Recommendations: Caregiver Considerations

Sample Outcomes

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.

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
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.

Feeding issues are complicated. Children need to FEEL GOOD before they can eat. (Edwards et. al., 2015)

Use Development As a Guide

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

Start with What is Working

FAMILIAR

(Morris & Klein, 2000)

Parent Coaching

Help Caregivers Learn a Child’s Cues

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

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 (Finnane et al., 2017)
- Respond promptly to child's cues of hunger and satiety (Black & Aboud, 2011)

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

Continuum of Options

Child Motivated

- Self-feeding

Adult Motivated

- Force feeding

(Klein, 2012)

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)

Behavioral Modification Strategies

Arvedson, Brodsky, Latten-Grief, 2010
I left this "left block" black to match the earlier slide (101) and reactivate prior knowledge.

Jones, Alissa Leigh, 6/5/2019
Feeding and Eating in Early Intervention: A Trust Based Approach

Building Trust with Families

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)

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

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?

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

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: Discussion

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

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)

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)

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
  • Ataxic movement
  • 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.
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