Provision of Feeding Intervention in the Context of Responsive Feeding

Feeding Fun Night 1.12.2019

Jenny McGlothlin, MS, CCC/SLP, CLC

"A critical component for all intervention with infants and children is the care provider's or clinician's ability to interpret the child's stress signals to keep the oral sensorimotor practice and feeding situations pleasurable and non-stressful, with no adverse health consequences."

-ASHA- Roles of Speech-Language Pathologists in Swallowing and Feeding Disorders: Technical Report

1. Primary goal of most families are for their children to enjoy food, to participate in family meals and peer events, and to grow/develop to their full potential
2. Many of the babies and children who present for a feeding evaluation or with a diagnosis of FTT do not have oral motor problems or skill problems with developmentally appropriate food textures
3. Feeding is much more than feeding skills, and must be assessed in the context of the feeding relationship as well as the emotional and developmental skills, abilities and desires of the child.
4. "In childhood feeding problems, it is difficult, if not impossible to separate behavior from biology" (Williams, et al, 2009, p 132)
5. Maternal feeding practices, predominately pressure to eat, significantly predicted food avoidance behaviors after controlling for child emotionality and maternal dietary restraint (Powell, et al, 2011)
6. Importance of Context & Relationships: How do we miss it?
    a. Taught to address feeding medically
    b. Standardized tools drive assessment
    c. Break down tasks into measurable parts
    d. Measurability for outcomes
    e. Specialty skill set for dysphagia and feeding- does it replace the basics?
7. Missing pieces in practice
    a. Child's innate ability to self-regulate intake sufficiently for growth
    b. Complexity of bodily system function & impact on desire to eat
    c. Developmental level and impact on feeding and the mealtime relationship
    d. Relationship and trust with food & caregivers
    e. Impact of stress on mealtime
    f. Skills in context of food presented
8. Language & Feeding: Malas, et. al 2017: Children with language impairment are more than three times more likely to have earlier occurring Feeding-Swallowing Difficulty/Concern when compared with the general population
9. Babies and Children are able to self-regulate intake
    a. Over 24 hour period
    b. Without instruction
    c. It can be impacted by
        i. Medical complications

        ii. Additional supplementation
        iii. Misreading of cues/pushing for more intake
10. Older children and adults do not self-regulate as well
    a. It can be impacted by
        i. Additional supplementation
        ii. Maternal and family pressure
        iii. Peer pressure
        iv. Media
    b. It can be taught
11. Growth and health are not the same thing, although growth is a component of health
12. Children can be small for a number of reasons
13. Insufficient data on the impact of nutritional supplementation on cognition and growth
14. Significant amount of data on the negative impact of stress and mealtime pressure
15. Considerations in development: attachment, interaction, developmental level
    a. Attachment
    b. Interaction
    c. Developmental levels
        i. Homeostasis and attachment
        ii. Separation/Individuation
    d. Development of autonomy
16. Attachment Research:
    a. 1978: Pollit et al showed quality of parent–infant interactions (as measured by mother and newborn feeding behaviors) predicted infant growth velocity during the first month of life
    b. Chatoor's Research
        i. 2000: feeding interaction is one which is central in establishing a parent's dyadic relationship with his or her child
        ii. 1998: In terms of malnutrition and attachment security, percent ideal weight positively correlated with attachment security
            1. suggests that the closer the toddlers were to their ideal weight for height, the more securely attached they seemed
    c. Children with secure attachment histories have been found to have fewer emotional problems at each developmental stage. (Sroufe, 2000)
17. Interaction Research:
    a. Substantially less maternal interaction at mealtimes with weight faltering children compared to normally growing children (Robertson et al., 2010)
    b. Hypothesis that a common pathway involves the interaction between food refusal and intrusive feedings: generally, intrusive feeding provokes food refusal with decline of caloric intake (Levine et al., 2011)
    c. Maternal feeding practices, predominantly pressure to eat, significantly predicted food avoidance eating behaviors after controlling for child emotionality and maternal dietary restraint (Powell et al., 2011)
18. Imitation Research:

a. Children are more likely to eat foods when an adult is eating it, rather than just offering it. (Adessi, 2005; Dovey et. al, 2008)
b. Pre-school children are more likely to eat foods that a teacher is also eating, but peer modelling is often more effective than the teacher. (Adessi, 2005)
c. Children were more likely to eat foods that are the same color as their parents. (Adessi, 2005)
d. Infants are not just learning to eat the foods they are given; they are also learning by watching adults eat, and figuring out who eats what foods with whom. Infants expect people to share food preferences, unless those people belong to different groups, suggesting human reasoning about food preferences is fundamentally social. However, infants generalize disgust toward a food even across people who belong to different groups, suggesting that infants are particularly vigilant to social information that might signal danger. (Liberman, et. al, 2016)
    i. See Babies Watching People Eat, New York Times for article about this study

19. Social Influences on Eating – Research:
    a. Critical periods when developmentally supported care makes a difference in brain and in later outcomes. (Als, et. al, 2004)
    b. Two experiments reveal that human infants exploit social information provided by adults to guide their choices in the food domain, prior to the onset of neophobia and domain-specific reasoning about foods (12 months). (Shutts, et. al, 2009)
    c. Children imitate adults for different purposes & if they are less confident in their own abilities, they are more likely to imitate exactly what they see (Over & Carpenter, 2013)
    d. Infants as young as 12 – 14 months imitate or reference socially those who are familiar or reliable. Begin to turn to authority figure rather than mom in novel place like a laboratory. (Hamlin & Wynn, 2012)
        i. Early social behavior helps 16 month olds determine whose food preferences to imitate
        ii. More likely to try foods that were "liked" by the helpful puppet, rather than the unhelpful puppet
20. Parental Control Research:
    a. Initial evidence indicates that imposition of stringent parental controls can: enhance preferences for high-fat and energy-dense foods, limit children's acceptance of a variety of foods, and disrupt children's regulation of energy intake by altering children's responsiveness to internal cues of hunger and satiety. (Brown & Ogden, 2004)
    b. Rewards for foods resulted in decreased intake of that food or a dislike of that food. (Savage, 2007) (Galloway, 2006)
    c. High parent control increased weight gain for kids are risk for obesity and slowed weight gain for kids at risk for underweight (Blisset & Farrow, 2007)
    d. High parent control can develop preferences for high-fat, energy dense foods (Birch & Fischer, 1998)
    e. Parent's control of meals leads to poor self-regulation (Savage, 2007) (Savage, Fischer & Birch, 2007)
    f. More intake if not pressured to eat (Galloway, 2006)
    g. High parent control led to negative mealtimes and picky eating (Van der Horst, 2012)

21. Temperament impacts feeding, reciprocity, & how child engages with food
    a. Disorganized (self-regulation), quick to upset or easy to soothe, easy vs. Hard to read (attachment)
    b. Curious/adventurous, suspicious/cautious, or somewhere in between
    c. This differs early on: picky eaters show slower suck pattern in infancy!
22. Parents of kids with a feeding disorder often feel personally responsible.
    a. Can impact parents' self-esteem and confidence as a parent
    b. Increased stress over repeated failed meals
    c. Negative mealtimes add to fear and avoidance of future mealtimes (Greer, 2008)
23. Significant feeding problems can be experienced as trauma. Emotions from earlier medical trauma can impact feeding relationships later.
    a. Up to 80% of ill or injured children will experience some traumatic stress following life-threatening injury or illness. What if we pair that with a learned aversion from reflux, aspiration, and negative oral/medical experiences?
    b. For families who were fearful that their baby couldn't come home until their baby ate enough, who thought their baby was dying "before their eyes", who were told they couldn't have surgery until a certain weight
24. Symptoms of Traumatic Stress (sound familiar?):
    a. Re-experiencing (Thinking a lot about the experience, feeling distressed at thoughts or reminders, having nightmares or flashbacks)
    b. Avoidance (Avoiding thinking about the experience, avoiding places or events that bring back thoughts)
    c. Hyper-arousal (Increased irritability, trouble concentrating or sleeping, exaggerated startle response, hypervigilance – always expecting danger)
    d. Other (new fears, psychosomatic physical symptoms, dissociation)
25. NICU Considerations: Catherine Shaker, *Reading the Feeding* 2013
26. Therapist or Parent: Often the most fragile future eaters are exposed to techniques and strategies that that are in direct opposition to what we know is important about creating a healthy relationship with food.
27. Feeding issues of longer duration tend to increase parent-child conflict over food selection and decrease child food acceptance. (Mascola, Bryson, & Agras, 2010)
28. "Children do well when they can" *The Explosive Child*, Ross Green, 2010
29. Kids Eat for Pleasure (Fulton, 2010)
30. Rethink behavior
    a. Behavior is Communication! Problem behavior is communication about a *problem*
    b. Purpose may be getting someone's attention, stopping an activity they don't like, or gaining sensory pleasure
    c. children feel unsafe or out of control, so they take inappropriate action over the things they can control, like refusing food to be placed in their mouth

31. The Power of No: In general, parents react [when the toddler uses No by not eating a particular food or not eating any] in one of three ways (Slaughter and Hope Bryant 2005)
    a. by accepting and supporting the child's choice
    b. by pressuring or forcing the child to eat the food
    c. by withdrawing from the child emotionally
32. What is Responsive Feeding?
    a. Responsive feeding IS responsive parenting
    b. "Non" responsive feeding "has the potential to undermine the child's trust in otherwise responsive parents." (Black and Aboud, 2011)
    c. DOR (Satter) "operationalized" (English, 2009)
    d. Best practice for childhood feeding AND with pathology (Kerzner and Chatoor, 2015)
    e. Associated with more stable BMI, less over and underweight
    f. Across SES and countries

Responsive Feeding is:

Mealtime guidance that depends upon the feeder's ability to read the eater's cues in order to make the meal manageable, enjoyable and successful for the eater, while retaining developmentally appropriate structure and expectations. It is not only child-led or fully adult-directed, but an ever-evolving dance between the two.

In other words, responsive feeding requires the ability to:

1. Set up a safe environment that is developmentally and experientially appropriate for the child
2. Read the child's cues of interest, fear, and curiosity
3. Make modifications for continued enjoyment and for developmentally appropriate progression
4. Maintain appropriate limits
5. Make changes as necessary in times of illness, growth, maturation, and environmental changes

33. Pressure can be subtle (Spectrum Pediatrics):
    Force feeding (The Mafia)

    Distracting for every bite (The Rodeo Clown)

    Hovering at mealtimes (Pushy Waiter)

    Cheering every little attempt (Parallel parking for an audience)

    Talking only about food (Used Car Salesman)

    Going straight to the mouth with the spoon without allowing an "introductory period" (Bad First Date)

    Continuing to pressure after a child says no (Bad date. Always.)

34. Steps to help families:
    a. Responsive feeding
    b. Relationship first; build trust

c. Setting the stage
d. Reading cues
e. Follow their lead
f. Lead by example

35. Understanding the Trust Triangle (Jenny McGlothlin 2016)
    a. When incorporating the responsive feeding approach into therapy, you can't separate the child's reactions to food from the larger feeding context, just as you can't separate the sensory and motor systems when viewing feeding skills.
    b. The dynamic triangle helps us understand the relational aspect of therapy.
        i. Child relationship with parent/therapist: child learns what and who to trust when it comes to food, with the child's challenges filtered through that dynamic
        ii. Parent relationship with therapist: parent learns new way to view their child's behaviors and how to promote improved skills
36. Responsive Therapy in Action
    a. Help parents identify distress or refusal cues
    b. Help parents discover verbal and non-verbal cues that contribute to distress and trigger anxiety or refusal
    c. Work with parents to discover new ways to start feedings or present foods that are more conducive to shared enjoyment and engagement.
    d. Give suggestions for food items that match child's level of skill, comfort, and sensory need.
    e. Model phrases such as:
        i. "I can ….."
        ii. "Sometimes I like to…"
        iii. "I wonder what would happen if I… (broke this, dipped it, mashed it, combined it with this)?"
    f. Use language that gives the child an option, and avoids giving them a directive which they then may resist or reject.
    g. Help with developing developmentally appropriate limits without coercion
        i. Staying in the chair without forcing food
        ii. Appropriate ways to decline foods
            1. Importance of allowing & acknowledging "no"
    h. Model goals of enjoyment, engagement, shared activity, requesting, interest, etc. rather than volume and "acceptance"

Additional notes:_____

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Jenny McGlothlin, MS, CCC-SLP, CLC, Faculty Associate
Director, STEPS (Supportive Treatment of Eating in PreschoolerS) Program
Co-Author, *Helping Your Child with Extreme Picky Eating* & *Conquer Picky Eating for Teens and Adults*
extremepickyeating.com
University of Texas at Dallas Callier Center for Communication Disorders
2895 Facilities Way
Richardson, TX 75080
972-883-3606
Jmcglothlin@utdallas.edu