Part 1: Feeding Responsively: An Introduction

1. Introduction
    a. Feeding therapy in our community
        i. Therapist feeding the child vs. supporting parent-child relationship
    b. Feeding is connected to bonding
    c. Importance of knowing which service providers should be supporting families
    d. Open conversations help providers understand each other's training and backgrounds
2. Introduction to Responsive Feeding
    a. https://rightfromthestartnj.org/development/11-development/38-what-is-responsive-feeding.html: "Responsive feeding is an active and also an interactive process: paying attention to the baby while offering food, watching her reaction, learning cues, and responding promptly and supportively to her needs."
    b. Reciprocity is central: both parents and kids participate
    c. "During the first year, infants and caregivers learn to recognize and interpret both verbal and nonverbal communication signals from one another. This reciprocal process forms a basis for the emotional bonding or attachment between infants and caregivers that is essential to healthy social-emotional functioning." (Black & Aboud, 2011)
    d. Parental concerns often include volume of intake and growth
        i. Responsiveness is an important place to start
        ii. Feeding builds trust between parents and kids
3. Continuum of Options in the therapy community
    a. Child-motivated vs. adult-motivated
    b. We want to be helping children to build internal motivation
    c. If we are using approaches that are adult-motivated we might reach a goal in the short term, but we are not building internally motivated eaters in the long haul

d. Parenting styles influence feeding practices
    i. Behavior management, desire for compliance vs. responsiveness
        a. Stress and worry can cause more controlling practices to be used
        b. Start with, “What is working?”

e. What is the goal of therapy?

i. To “Get the child to eat?”

ii. Build enjoyment- not as measurable initially

iii. Initial goals often include volume of intake and growth parameters

4. What is responsive feeding?

a. Maureen Black & Frances Aboud: Responsive Feeding is Embedded in the Theoretical Framework of Responsive Parenting (2011)
    i. Four primary characteristics of responsive approach
        1. Prompt
        2. Emotionally Supportive
        3. Contingent
        4. Developmentally Appropriate (eating opportunities)

5. So how do we begin?

a. Feeding issues are complicated: Children need to feel good before they can eat well
a. Part of seeking answers is helping parents understand their children and acknowledge parent’s experiences of stress and worry
b. Revisiting parents’ goals
c. Start with emotional connection and climate
d. Help parents understand why we want to start responsively
e. Use responsive approach as we seek answers for other underlying issues

6. Responsive Feeding is recommended/supported by:

    1. World Health Organization
    2. Pan American Health Organization
    3. American Academy of Pediatrics

Part 2: The Top 10 Things that Might Disrupt Responsive Feeding

1. Introduction
2. Quick review of responsive feeding definition
    a. 4 Pillars: Prompt, Emotionally Supportive, Contingent, Developmentally Appropriate
    b. Responsive feeding helps to build strong and trusting relationship between parent and child
3. The Top Ten Things that Sabotage/Get in the Way of Responsive Feeding in Therapy:
    1. Sometimes parents and therapists have different expectations about what feeding therapy will look like.
        a. Expectations are important: Parents may think that feeding therapists are going to be the ones to come in and 'fix'/feed their kids
        b. Responsive approach means we are coaching parents
        c. Matched expectations are critical; communication is what makes this work
    2. Kids bring past experiences to the table that we may not know about yet.
        a. Those experiences may have taught child that feeding doesn't feel good
        b. Working to understand how that happened helps us make a plan

   c. Take the time to listen to parents and ask good questions

3. We may not completely understand what a child is telling us at the table.
   a. Feeding is a relationship that depends on both partners
   b. A child's cues may be confusing/unclear because of underlying medical or developmental factors
   c. Parents may not know what to look for or may misinterpret cues
   d. Responsive feeding means we start by understanding the child
   e. Parent is the expert: Ask parent questions to figure out what behavior might mean
4. Progress may happen slowly
   a. What is the goal? "Get child to eat" vs. help child become a confident eater
   b. How do we measure progress?
   c. Marsha Dunn Klein: adults set direction, kids set the pace
      progress is not always linear
   d. Celebrate small steps
   e. May take time to seek answers from other professionals
5. It is hard to balance volume or weight gain goals with using responsive strategies.
   a. Parents may have been given a goal for volume that has caused the focus to be primarily on quantity of intake

b. This kind of stress may cause parents to use non-responsive strategies to reach those goals.
c. Parents may not understand that intake can/should vary and growth rate may vary
d. Education is key- collaboration with other professionals is a good idea (e.g., RD, pediatrician)
e. "Sometimes your child will eat hardly anything. Other times she will eat more than you can ever imagine. It is all normal. […]The average toddler eats from 960 to 1700 calories a day. Add on to that a normal 20% over and under day-to-day variation, and that child will eat between 760 to 2040 calories a day." -Ellyn Satter

6. Typical developmental stages may seem more problematic when feeding is already hard
   a. Teething, illness, neophobia- power struggles can ensue
   b. Parents who have been worried about feeding, weight, etc. may not recognize these as developmental stages
   c. Plateaus: Child may need to build confidence through practice/repetition with newly learned skills,
7. Parents get a lot of varied advice from well-intentioned friends and family.
   a. Everyone has ideas based on their own experiences
   b. Hard for others to understand parents' experiences
   c. Parents may second-guess themselves, may not know development

d. Education is key
e. We can help build a parent's confidence
f. Bring other caregivers into the discussion, consider cultural practices

8. A parent's own relationship with food may negatively influence the way they feed their child.
    a. How the parent was raised around food influences the choices they might make
        i. rules like "clean your plate," "no thank you bite"
        ii. belief that child needs to behave and comply at the table
    b. Nonresponsive feeding has been associated with the development of poor dietary habits and/or increased childhood obesity
    c. Parents may consider a child's preferred foods to be "junk," or not "good" choices
9. Caregivers may not understand or respect their child's preferences.
    a. Perhaps more relevant with older kids
    b. Eating is sensory experience
    c. We all have ideas about what we like and don't like
    d. Parents may not understand child's "rules" around what he/she will eat
    e. Child's preferences don't make sense to caregivers
    f. Frustration may cause a well-meaning caregiver to push beyond satiety cues or responding to and respecting a child's "no."
    a. Figure out what feels enjoyable and engage in those experiences more often

10. Providers feel pressure to "get a child to eat."
    a. Biggest way we sabotage our own therapy
    b. Might stem from different understanding of goals
    c. Relationships need to be strong and trusting
    d. Stress may cause provider to implement non-responsive practices to encourage consumption, and parents may not be able to easily replicate or sustain this.

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