Together At The Table: Working With Families
Recorded May 20, 2020

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SpeechPathology.com Course #9326 Part 3

- [Fawn] Welcome back to Part Three of "Responsive Feeding" series. This Part Three is "Together at the Table: "Working with Families." I have Stephanie Cohen and Karen Dilfer with us, and you ladies can get started.

- Oh, fun, thanks so much for that introduction. Today, we are gonna be talking about working with families. so this is an issue that's really near and dear to my heart, and Stephanie's heart as well, and Stephanie's here with me.

- Hi, glad to be back.

- All right, so we're gonna go through some learning outcomes. After this course, participants will be able to describe three ways a child's feeding challenges may impact the daily routine of a family, participants will be able to list at least four emotions a parent may feel when parenting a child with feeding challenges, and participants will be able to describe three ways clinicians can support the mental health and well-being of parents as they work with children with feeding challenges.

- So in the first webinar of this series, we shared a lot of information with you about how, from birth, the typically developing feeding relationship supports bonding and the development of a trusting relationship, and we also discussed how disruptions in that process can impact parents emotionally, leading to things like increased stress, conflict between caregivers and their children and between caregivers and perhaps their partners. So today we would like to revisit some of those ideas, share more of the literature with you, and share our recommendations for building trust with parents. We're also gonna discuss some potential barriers to building trust with families, and we hope that today that you can take some actionable ideas with you to use in your own practice. Additionally, we're gonna share a few videos of parents describing their own experiences. So we wanted to put this photo up again to remind you of our discussion

about how when the feeding relationship begins to develop from birth, a child trusts that her parents will feed her, and the parent trusts that the child will want to eat. But in the next portion, we're gonna continue and sort of dive in a little bit more deeply into how feeding challenges can really disrupt that relationship and the formation of that trusting bond. So we wanted to share this paper with you. This was published last year, and the author surveyed 29 parents of infants younger than seven months, and they asked them to describe their infant's feeding experiences and their experiences feeding their young infants. So what we wanted to point out is that the parents of children who had no feeding issues at all spoke of the parent-child relationship only within a positive frame. So it was the idea that those feeding experiences really were opportunities to bond and get to know each other. In contrast, the parents of children who were experiencing difficulties didn't share anything about the effect of feeding on the relationship, but instead, focused more on how difficult it was for them to feel like they couldn't figure out the problem and help their child.

So we wanna share this quote with you, and we know that many parents with children with feeding challenges are given a variety of information, things like targets for weight gain and caloric intact, and so we wanted to share with you what might happen in that situation to a parent. "Controlling feeding may arise "when children experience problems in feeding or growth "such as recovery feeding after an illness. "Under these circumstances, recommendations tend to be guided "by a children's nutritional needs, "a child's nutritional needs, "focusing on the quantity and quality "of the food and the frequency of the 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." So as we shared with you throughout the webinar so far, some of these recommendations might push a parent to use some strategies when feeding his or her child that perhaps disrupt the balance and interrupt that process of trusting each other. When we think

about a parent's experience at mealtimes and the stress that often accompanies feeding a child who might be having difficulties, we want to remind you that parents are often stressed before, during, and after feedings. You know, for infants we know that a typical feeding schedule means that that infant eats between eight and 12 times a day, and for toddlers, mealtimes occur between five and eight times a day with meals and snacks. So we encourage you to understand that as parents share their experiences with you, we want to remember that this really, the stress really is all-encompassing for many parents as they reflect on, perhaps, a feeding that has just ended, and begin to anticipate the next mealtime and the challenges that may come with it.

- I'm so glad you brought that up, because I think that feeding struggles are unique in that parents need to keep feeding their kids over and over and over again. It's not just a stress that you deal with and then it's done, but it keeps happening. So really, feeding challenges have the potential to just take over a parent's life. So we wanna dive into that idea in this next section and really explore what the parent experience may be. These are some emotions that were actually from that Pados and Hill article that you referenced earlier, just that parents who have kids who struggle to eat may be experiencing serious grief, they might be impatient, they might be really frustrated, they might take it personally and feel like a failure, or they might be really confused about why is this happening and how do I actually help my child? We wanna highlight this article from 2002. This was an article that looked at the lived experience of parents who had children with the diagnosis of failure to thrive, and if you're not familiar with the diagnosis of failure to thrive, what that means is that kids aren't growing well.

So oftentimes, kids are really small, maybe at risk to get a feeding tube or undergo some other intervention that would help them gain weight or be bigger than they are. The parents in this study described being in constant fear. They were afraid that their child's inability to eat was gonna cause their child to have a feeding tube or to undergo

additional medical procedures or help or be on medication. Parents felt helpless, they felt isolated, like other people didn't understand what they were going through. It was really, really hard when their kids got compared to other kids and their family or the children of family or friends. Then this last point is that parents described not being heard by medical professionals. We really wanna draw your attention to that point, because we oftentimes are those medical professionals, and when we ask parents questions, when we really seek to understand their experience, we are helping them, and that in itself is therapeutic. So we thought that we could practice of our active listening skills here, and we wanna show you a video. This is a video of a mom and dad who I worked with. I worked with their son, and I just want you to listen for their experience, and listen for the stress and frustration in their voices.

- It was just very stressful. The feeding times were extremely stressful. They were affecting our family life. We have a four-year-old son, and we noticed his behavior changing at the time. I was in tears every time, breakfast, lunch, and dinner, snacks, I was in tears. Then, that one time that we went apple picking, and Charlie went eight hours without eating. He didn't drink anything, he didn't, he refused, at that time I was half breastfeeding, half bottle-feeding, he refused to hold the bottle, he refused the breast, and then, what, we got home and we said that we needed to do something, even though we didn't wanna do it. But that was the point, I think.

- Yeah, yeah.

- So these parents just were really stressed and really upset that their little guy who was probably about eight months old at this point was just refusing to eat at every opportunity. So that's when they decided that they needed to get a feeding tube, and that was a really hard decision for them. That decision was made with the help of myself and then their, the child's medical time. They had a GI doctor, we worked with a

speech pathologist. But it was really a journey in helping them figure out how they could best support their child.

- We wanted to share this next graphic with you to sort of further demonstrate that families may have gone through a lot before they even get to us, right. So this is a graphic from the book "Love Me, Feed Me," my Dr. Katja Rowell. She describes the worry cycle in which a child has a feeding challenge, the parents get anxious, they start to worry about their child's eating, they may not have good information, or they may not have a great support network. They might even get some advice that is not so great, and they start to implement some counterproductive feeding practices as we described a few slides ago with the definition that I read to you, or the quote that I read to you. That counterproductive feeding practice, you know, often results in further resistance from a child who might feel that pressure, but still doesn't feel comfortable with eating, and then it really begins to sort of spiral, where the parent gets more worried, exerts more pressure, and we wanna say that we are not judging parents by any means, but we're just understanding that parents are worried about their children, and they are doing anything that they can to help that child to eat.

So by the time they get to us, we might be the practitioners that can help parents sort of unpack all of the experiences that they've been through, and give them some advice to support them from that point on. You may have heard about the study we're gonna talk about next in the mainstream media. Nancy Zucker and her coauthors looked at children who they sort of referred to as moderate or severe selective eaters, and they found that having those sort of characteristics or profiles was associated with psychopathological symptoms, things like anxiety, depression, ADHD, both at the time and then down the line. And it got a lot of attention. But what we found interesting, and relevant to our discussion today is the point that they made that 63% of the parents that they surveyed reported along the way that they did not feel heard by healthcare professionals, they didn't feel that their concerns were addressed. So I think Karen and

I, both based on our clinical experience can say that this didn't surprise us, because the number of families report to us that they have been frustrated along the way and don't feel like they've gotten maybe the right kind of support. So we really have a wonderful opportunity to sort of set them on the right path. So in the thinking a little bit further about parents and their past experiences, we want to talk a little bit about trauma. We know that children who experience some of the things we discussed in the second part of this series may have experienced things that felt traumatic, and resulted in some changes in behavioral responses as a result of those hard experiences. We also know that those children have gone through those experiences with their grownups who are caring for them. So we just wanna read to you this definition. "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." So we put this photograph up to show you what a parent of a child who was born prematurely may have experienced. We know from the literature that mother's of pre-term infants in particular experience elevated levels of things like depression, anxiety, NICU-related and post traumatic stress, and worry, sometimes meeting the criteria for PTSD, and fathers do, too, and that this may have a negative impact on a parent's ability to be responsive to their child's needs. Parents who have had an infant that has been born prematurely, and has been very, very ill, may have lost trust early on that that child would even be able to survive much less be able to take in adequate nutrition to support that child's life and growth.

- So we wanna take a minute to talk about both trauma and trauma-informed care, because we know that those things are really, they're buzzwords right now, but they're really, really important concepts. When we're thinking about trauma-informed care, we're not talking about treating the symptoms or issues related to past trauma, but rather, we're thinking about providing support services in a way that's accessible and appropriate to the parents and kids who might have experienced trauma in their past.

So when we think about trauma and we think about stress, we can think about it on a continuum, right. On one end is normative developmentally appropriate stress that can even help build resilience, but on the other end, we can think about toxic stress or traumatic stress that is unpredictable, and can really just be harmful to both parents and kids. So we wanna talk about parents first, and then we're gonna talk about kids next, because we know that both parents and kids can really suffer from undergoing trauma in all sorts of different ways. So some of the events that might contribute to trauma for a parent could be separation from their child, a hospitalization, either of themselves or their child, the placement of a feeding tube. I think that's a huge one for us to consider as professionals. I personally work with a lot of kids with feeding tubes. I actually think feeding tubes are pretty great in a lot of situations, but for a parent to hear the news that their child needs to receive a feeding tube is huge and is really, really sad for a lot of parents. We also know that if a child receives a diagnosis, like maybe a child is diagnosed with having a syndrome or being on the Autism spectrum, that is an unexpected, life-changing event for a parent and for families, and so we wanna respect that, you know, that experience might be traumatic for parents. Then of course an acute event, something like a choking incident, an accident, something that no one expects that's going to happen. I think one of the really important things to consider as we think about trauma is that trauma is individual and specific.

So what that means is that we all have our own set of past experiences, we all have our own coping skills and the things that we're really good about being resilience with or our own resiliency, and so for certain people, an event might not be a big deal, but for other folks, an event could really be something that causes long-lasting effects. Post-Traumatic Stress Disorder is a term that you've probably heard, I know that Stephanie mentioned it earlier, and it's the, "mental health problem "that some people develop after experiencing "or witnessing a life-threatening event." I think it's worth it to say that it can be a life-threatening event for themselves or someone they love, like their partner or their child. The literature tells us that 10 to 20% of parents with

medically fragile children may have PTSD. I think that is an incredible statistic for us to contemplate, because we really need to go into situations of intervention with families just kind of assuming that people have experienced trauma, and that will help us provide intervention that's sensitive, and can really help parents and kids overcome those hard past experiences.

- Karen, I think it's important to note that you and I are not suggesting that we are the ones to work with parents and help them process all of their emotional responses and past experiences, that we may help them talk about the things that are related to feeding, we absolutely are pulling in our mental health colleagues to help us sort of figure out the best way to move forward with many of our families.

- Oh, I'm so glad you brought that up. You know, a lot of places have feeding teams. You and I both work in the early intervention context, and so sometimes teams are a little bit more diffuse or virtual, or we just spend a lot of time talking to those other professionals on the phone, and we know that from the beginning, we want that social worker, we want that therapist to be on the team, because they can really play such an important supportive role in helping both parents and kids as they go through the therapy process. So as we're thinking about trauma-informed care, working with parents, we know that some of the signs that a parent may be experiencing trauma or had experience in their past could be that they're re-experiencing those hard things that happened in the past and it's influencing their ability to be present. You know, I always think about, there's a family I treated for a long time, and the mom said to me one day, "Karen, I'm so glad that you come to my house "every week for therapy. "I just could not imagine going to the children's hospital "and receiving therapy in the outpatient center there, "because every time I drive into the hospital parking lot, "I relive that experience of when my little one "was in the NICU." And her little guy was really, really sick. He was in the NICU for a long time. For a while, they weren't sure if he was gonna make it, and every time that she had to go to the hospital, that mom

relived that experience of not knowing if her baby was gonna make it, and that was just a terrible things for her. We also know that people who've experienced trauma might just have behaviors that are hard for us to make sense of, like maybe those parents don't respond to our messages or our emails, maybe those parents seem to be really, really concerned about things that most people wouldn't think are a big deal. We could maybe think about that as hypervigilance. A lot of parents become really just concerned about the volume of food their child is eating, and that can be something that can be really easy for them to become upset about, or I can think about a parent who has a child who has a syndrome, is doing, did a lot of throwing up and refluxing early in life, and so now every time they feed that child, that mom is just so worried that her baby is going to vomit. It's really, really hard for her. So we just know that trauma can express itself in all sorts of different ways. So we can also think about this idea of the chronic stress continuum when it comes to kids, right.

We know that there are certain experiences of normal developmental stress that we would expect kids to go through, because we know that when kids go through kind of typical developmental stressful experiences, it can really help them become resilient individuals and develop coping skills, and in some ways, it can really help them bond with their parent, right. If you think about a child that's uncomfortable, or maybe they're hungry, and they cry, and they're experiencing that developmentally stress, a parent hears the cry, comes and gets them, comforts them, and that experience of stress really strengthens the relationship between the parent and that child. On the other end, when we think about toxic stress or traumatic stress, that occurs when a child experiences a strong, frequent, or prolonged adversity, right. If we're thinking about feeding, that could be something like aspirating, that could be something like being removed from a parent, maybe during an intervention or during a procedure. So that child doesn't know what's gonna happen, they're really, really upset, and there's no loving person there to provide that support and that coregulation.

- I think also it's important to think about this in regard to the parent who is going through those experiences with that child. You and I have talked a lot about those normal, developmental, developmentally stressful experiences that parents go through, like getting a babysitter for the first time. Those are things that have to happen. Not have to happen, but they're things that build our resilience and our tolerance with a little bit of a stressful situation, but that the parents, again, going through these stressful experiences, also have the potential to experience trauma along with their children.

- Yeah, you know, it's so important for us to also think about those current practices that we're engaging in with parents as we're treating kids, because we wanna be cognitive of the things that have happened in the past, but we also don't wanna cause more trauma in the future, or in the present moment as we're attempting to help kids. So you know, one of the things that I think about is, as feeding therapist as a profession, we have a really bad track record of supporting kids and parents, right, and we know that when kids and parents are separated, that has the potential to be traumatic. We also know that if we become a little pushy and ask kids, think older kids who can maybe understand a first-then concept, to do something in order to get a reward, you know, that also has the potential to be traumatic. Again, trauma is individual and specific, but we just wanna be so careful to make sure that everything we're doing as professionals, to really bring parents and kids together and providing trauma-informed care that is not gonna make parents and kids relive terrible, hard, past things, and re-traumatize them.

So real quick, if, when we're thinking about trauma-informed care, again, we're not thinking about treating symptoms or issues, but we wanna think about just how we're providing services so that we can be supportive. So we wanna recognize the signs and symptoms of trauma, we wanna realize that trauma is real, and trauma is impacting the families that we're working on, and then we wanna make sure that everything we're

doing as professionals is preventing, resisting against re-traumatizing parents and kids. And I just wanna make a note and say that if you wanna learn more about trauma-informed care, we would really encourage you to check out resources put out by the Substance Abuse and Mental Health Services administration. They're the people that contributed the information to this slide, and they just have so many great resources that can really inform your practice.

- So in this next section, we wanna give you some actionable sort of tips, we wanna give you more information about how we, as providers, can work with parents to form strong relationships, and serve as what's referred to in the trauma literature as buffers. So we know that buffers are things that help people who are going through stressful experiences go through them and process those experiences without having traumatic stress responses. We as providers and strong partners can really be that for a parent and help them to manage the stress that they're going through. We also wanna acknowledge that though we spent some time talking about trauma, because we think it's important to understand, we acknowledge that some of the families we're working with maybe haven't experienced traumatic things, but as we've discussed repeatedly, are feeling significant levels of stress, and that some of these ideas can support them as well. So when we think about building relationships with parents, we think about building what we would like to refer to as a therapeutic alliance, and you may have heard this term, but it really refers to how you and a parent connect with each other and build this bond that develops that relationship to the point where the parents feel comfortable with you, feel safe with you, and feel like they're able to share their emotional experiences, and you feel like, as a therapist, you're really able to ask some of those probing reflection questions to understand how that parent feels.

So it really is getting beyond just getting along and building rapport. If we build that therapeutic alliance well, then we can be a facilitator as the therapist for that parent and family to achieve their goals rather than an authority figure who directs the

process. So we're gonna continue talking about building trust and we're gonna talk about some aspects of the therapeutic process that can help build trusting relationships with parents, and then we're gonna focus a little bit on the use of language and the idea of judgment in the therapeutic process. So when we think about the therapeutic process, I know Karen and I talk a lot about this idea of coaching, and you may be familiar with Rush and Shelden. We wanted to share some of their ideas about coaching. Their book, "The Early Childhood Coaching Handbook" defines coaching as, "an adult learning strategy "in which the coach promotes the learners or coachee's ability to reflect on his or her actions "as a means to determine the effectiveness "of an action or practice "and develop a plan for refinement "and use of the action in immediate and future situations." So we want to continue to discuss some of these ideas that can be thought about as coaching in very specific ways relevant to our practice working with families with feeding challenges. So one thing that we can do is we can start in the assessment process bringing parents in and really seeking to understand the child's therapeutic needs from that parent's perspective.

So you know, assessments are a touchy time. Parents are anxious, they're worried, they may have a sense that's something wrong but they don't understand what might be going on. We know from a lot of the papers that we've shared with you, the qualitative research, particularly those studies with a phenomenological approach that focuses on the commonality of a lived experience within a particular group, that it's so important to understand parent's emotional experiences in their own words. When we understand those experiences, we can work together to identify goals and priorities. You know Karen, you and I talk a lot about how the success of really this process from the beginning hinges on having similar expectations, and we talked about, in the podcast, if you were able to tune in to that, that one thing that can derail this process is when parents and clinicians have different expectations. So we wanna make sure that parents understand that we respect their view, we view them as the expert, and we are just here to facilitate progress towards their goals. So we can also include parents in

treatment in a variety of ways, but what we encourage you to do and what we try to do in our own practices is allowing that parent to identify, really from the assessment point, what is working right now. I think when we start our sessions with that type of a discussion, not only do we set a positive tone for the session and for the discussion, but we understand maybe our starting point, and then how to move towards maybe a longer term goal. You know, when we ask parents in the beginning of the session, "What would you like to work on today," we give them the power, or really, we demonstrate to them that they are the leaders in the process. So they're helping to choose the activity, they're the primary mealtime partner with their child. So it's not the therapist feeding the child directly, though we may demonstrate some strategies or sort of explain to the parent how to try something, but what we really wanna do is make sure that then we're pulling that parent in as soon as possible so that they feel comfortable with those strategies, and or let us know that we might need to tweak things to make it feel like something that will work for them.

- You know, I'm so glad that you shared those things, because one of the things that I always think about is, you know, if I don't have a relationship with a parent and I go in there and I say, "Oh, these are the things that aren't working, "these are the things that are hard, these are the." You know, as therapists, we like problem statements, right. If you start those, oftentimes I think that you lose parents, they stop listening, because they're like, you don't see my child as a whole person, you don't really understand the things they're doing well, right. Parents love their kids, and I think a therapist can really almost be a threat to that relationship if we just go to those things that are hard and the things that aren't working for parents and kids.

- Yes, and our language is so important. So some, we wanted to give you some specific strategies for those conversations. So we might use some of these prompts, saying, "You know, I'm noticing that," you know, "Sean turns away or throws the spoon "every time he can't successfully "bring it to his own mouth." We might wanna

make a gentle suggestion by saying, "What would happen if you supported Sean "by putting your hand over his "and helped him to bring the spoon to his mouth?" You might also say, "Could we try "offering a different spoon?" "What would you think about pre-loading the spoon for him? "Is that something that you would like to try?" Then, if we're gonna demonstrate a strategy, remembering to ask for permission. "Would it be okay if I showed you "how to support him when he tries to feed himself?" So I think these are all things that are very easy prompts to incorporate, ways to change our language. We want to, again, continuing to include parents in treatment by prompting the parent to reflect on what worked, and really actively listening, not just waiting for our turn to share what we think worked or what we think we should work on, but really allowing parents that space to reflect, and then sharing our own reflections, and then really letting the parent guide the process from that point on. So we wanted to bring back this slide from one of the past modules of this series. These are those reflection prompts that we shared with you that are specific to this session. We're not gonna go through them again, but we wanted to just remind you that these are here for you to try, and again, remembering that we want parents to bring their own ideas to the discussion rather than us just sharing our ideas, so giving them that ownership and independence with problem-solving at mealtimes. This is just how we continue to build trust with parents through the therapeutic process.

Then finally, home programming, so again, asking parents, what worked today, what felt comfortable for you? Offering a few options for integrating new strategies, so I often like to say to parents, "Hey, we brainstormed a lot of different things today. "Here are some of the notes I took. "Which one would you like to try," or, "Which ones do you think would be easy "for you to incorporate this week," letting the parent choose what to implement that week, and try at home. We want that parent really just ultimately to feel comfortable at each mealtime, feel confident, and have a game plan. There are a lot of considerations that we want to bring to your attention as you're planning home programming with parents. We know that some days, parents are more stressed than

others, especially with the current climate, what's going on in the world. Just yesterday, a mom that I'm working with expressed that she just hadn't had the energy to work on feeding with her daughter the past couple weeks. So what I realized in that situation is my job was to help her to forgive herself and understand that that's okay, and that if we just maybe focus on connection and enjoyment at mealtimes, that, you know, that's progress, right, looking for those moments of celebration and joy. We want to make sure that the recommendations we're making are in line with the family's financial resources, that we're not suggesting they run out and buy a whole list of different foods or expensive utensils, but that we're problem-solving in ways that the family really feels like we understand what their resources are. Time is also another resource that we wanna be cognizant of and thinking about. We don't want parents to feel overloaded, and I think that again, setting the tone with parents from the beginning, that we know that their lives are busy, we want them to feel comfortable sharing what they feel capable of, that we won't be judging them, really allows us to understand more fully and make appropriate recommendations.

Outside support is so important. We've talked a lot about that, but just knowing whether this is the only person that can feed this child, or if there are other family member that are this, supporting this family, really will help us to assess appropriate plans. Talking about, or thinking about parent's cognitive ability, they may need us to use simpler language, to write things down. They may want information provided to them in lots of different ways. So just understanding individual capabilities is so important. Then we've talked about a parent's personal history in regard to traumatic experiences or how a parent has been brought up around food experiences. Those are really important things to consider. Cultural practices are something that Karen and I talk about a lot. When we think about cultural considerations, we wanna make sure that we're culturally responsive, and that's really about this idea of reciprocity and mutuality is, you know, just understanding a family's learning around food experiences, as I just said, but valuing their knowledge and expertise, what their culture values in

terms of helping children learn to eat is so important, so that our recommendations are in line with the values of not just the parents but maybe extended family members. When we address those considerations, our outcomes are better and just more appropriate for families. Lastly, thinking about frequency considerations when we're working with families. Different families need different levels of support. So I think about a baby that I'm working with. You know, we're making changes in terms of his bottle-feeding recommendations, and it's not appropriate in this case to wait a week before we touch base again, so we use a variety of different ways of communicating. They share videos with me, we text back and forth, this is all with their permission, this is what they're comfortable with, and then we talk in between appointments. But it's not just our decision in terms of the frequency of contact, though we do wanna consider perhaps our personal boundaries and make those clear to parents, but we also want parents to understand that we are there for them throughout this experience, and helping them to have those expectations that they don't have to feel like they're imposing on us if they need to reach out to us. Just thinking about how often they're going through those mealtimes can help us to really remember that that support might need to happen more frequently.

- So we wanna talk about some things that might get in the way, and that, things that could be barriers to this relationship with parents, and barriers to trust as we're working with families. So these are things that might come from some personal experience, and we're gonna talk about barriers that might be found more in like parents or families, but then also things that we might bring to the table that make eating hard. So when we think about parent and family factors, we talked a lot about past experiences and the history of trauma, and we wanna highlight that parents might have a mistrust of professionals, right. They might not be willing to trust us from the beginning, and really, I think that's okay, and I think that makes sense, because we know that parents are doing the best that they can, and parents are demonstrating that mistrust for good reason. So it's really on us to do our best to build trust with those

parent, to really help parents see that progress in their children, because we know that when parents see that, oh wow, therapy is working, that builds their trust in our recommendations and our work together. We know that a parent's food history and the way that a parent or a family was brought up around food really can influence the way that a parent is expecting their child to eat. I can think of a situation in my own practice where a dad really wanted his eight-year-old son to sit at the table, to have good table manners, to finish what was given to him. For that child, that wasn't really what that child was able to do in the moment, for good reason, based on his own struggles, but that was a conversation that we needed to have and we needed to work through. It helped me understand where the father was coming from, and it help me make better recommendations for that parent and child to work together and have mealtimes together that felt good.

We also know that a parent's own mental health can play a huge part in their relationship with their child, and again, when I think back to my own experience, some of the most challenging families that I've worked with have had parents who have shared that they've had significant mental health struggles. I can think of one mom that had really significant anxiety that just made feeding her child so difficult, and then another dad who divulged that he struggled with bipolar disorder. So we wanna make sure that we are being supportive of parents, but also that, you know, we wanna do our best to make sue that parents are taking care of themselves. Then the last thing that Stephanie mentioned earlier is it's so important for us as professionals to realize that you know, parents might have other disabilities or things that might make it hard for them to learn or to feed their child well. So we wanna do our best to use different supports to communicate well, and really to ensure that parents understand our role and the recommendations we're making. Because even if we're making great recommendations and we're doing our best as therapists, if it doesn't make sense to a parent, or they don't understand it, we're not gonna see the outcomes that we really wanna see. So some of the things that might get in the way of building trust on our

end, you know, well, maybe our own past experiences, including things like implicit bias or judgments that we have, right. Stephanie and I talk a lot about giving parents the benefit of the doubt, and we really, sometimes I have to remind myself to give the parent the benefit of the doubt, because I don't know what has happened in that person's past, or what has happened maybe prior to that interaction that we've had together. We wanna be able to grade our communication so that we can really make sure that what we're communicating makes sense to the other person. Then the last thing I'm gonna say, and then Stephanie, I'm gonna let you jump in, 'cause I know that you have things to share, too, is that we really wanna make sure that we're doing a great job identifying progress rather than focusing on the impairment, right? That's kind of what I said earlier. We just don't wanna go in and say, "Oh yeah, they're not doing this, "and they're not doing this, "and they're not doing this." We wanna talk about all the ways that we see that child progressing, all the ways that we see that child thriving, and then point out all of those little baby steps that we see a child succeeding in. One of the things that I always think about is, you know, when you think about picky eater types, maybe toddlers, oftentimes, you know, therapists just want kids to interact with food. I want kids to interact with food, because that helps them engage in sensory learning, it gives them a preview of what the food might feel like or taste like in their mouth. But oftentimes for parents, the parent will go, "Why are you so excited that they're messy, "that they're fingers are messy? "Now I just have to clean up the mess." But you know, when that interaction happens, or when there's a breakdown, that's on me. I didn't do a good job of explaining why we're engaging in that activity, and why the child, why are, we're celebrating that step in the therapeutic process.

- Absolutely, and I just, when you talked about bias and judgment, it really made me think about the fact, again, we keep saying this, but it's important to repeat, that parents are doing what is working, and when parents are doing what is working, we really need to acknowledge, again, that idea that they just are worried about their children and they're doing what they can to help them participate in mealtimes.

- So we wanna talk about language and judgment, because we know that so much of the interactions that we have with parents are really dependent on again, where we're coming from, but also the words that we're using as we're interacting with moms and dads. So this is the definition of judgment, and what I wanna highlight for you in this definition is that you know, implicit to a judgment is an opinion, right, and we all have our own opinions, and that's okay, that's a part of being a person, but when we're working with a family, we wanna do our best to be neutral, and to really understand where that parent is coming from, because oftentimes, when we understand why parents are doing the things that we're doing, we don't necessarily need to judge them or make judgments, right. Like Stephanie just said, parents are really good at doing what's working. I always think back to the example of an iPad. You know, it's really easy for us as therapists to go into situations and say, "Oh yeah, that's not good, you shouldn't be doing that." You know what, oftentimes a parent knows that the shouldn't be doing that, or they don't wanna be doing that, but they're doing it because it's gotten them through the day. It is getting the calories in that child's belly and keeping them off a feeding tube. It is providing that consistency of routine that that parent needs to make it through a family dinner.

So we just wanna be so careful about our own contributions to this therapeutic alliance. So we wanna be so careful the language that we use as we're assessing and describing children's, and a child's eating patterns as well as the foods that they're eating. We know that parents are so good at figuring out what's working for their child in a situation, and so while we might judge the use of something like an iPad, we know that a parent is using that iPad because maybe it's getting them through that mealtime, right, or maybe they know that when their child is watching a screen, they're zoned out enough that their child will receive calories, and you know, maybe that parent is really worried about that child's growth, or is afraid that that child is gonna need a feeding tube. So I think when we understand the reasons behind why parents are doing

specific things, it causes us to be way less judgmental, right. I think another part of this is we wanna be really careful about the language we're using to describe food. I think that, you know, one of my least favorite phrases right now is this phrase of clean eating. What does that mean, really, and if the foods aren't clean, are they dirty, right? Did you wanna contribute, Steph? I know that you have lots of things to say here, today?

- Oh, yes, absolutely. I think about the parents who might also describe their kids as only liking junk food, or just liking carbs, and they almost, sometimes, it begins to sort of become a characterization of the child as a whole. So we want to help parents to understand why some of those foods might be working for their child, and even though they're not yet eating some of the things that the parent may want him or her to eat, we'll get there. But I think when parents understand why their child has those preferences, it changes their perspective just a little bit.

- Oh, that's such a good point, and you know, also I think to go along with that, we want parents to understand that kids are doing the best that they can, you know.

- Yeah, absolutely.

- And oftentimes, kids like those carby, junky, snacky, not clean foods, because they're the same, or because they break down really easily, right. So I don't know, we could talk about this for a long time, but we're gonna keep going on and talk about language we use to describe children. So these are some terms that are some of my personal least favorite words that maybe I've seen, you've seen. I, sometimes I read them in reports that I get from other professionals. But I think that these words can be really, really hard for parents to hear. I would also argue that I think that these words sometimes do a poor job of communicating, really, what's going on with a child.

- Absolutely.

- So what we wanted to do is just to provide you with some alternatives of words that you might use that are a little bit less judgmental, and might communicate what you wanna say in an even clearer way. So instead of saying aversion, we might say that, "The child is cautious," or, "This child has had bad experiences." Instead of using the word food refusal, we might say, "He's sensitive, "he's choosing to say no, "he's not yet ready for this," right. We're not putting that refusal as a label on the child. We're describing that child's experience or that child's actions. Instead of saying a child is delayed, we might say, "She's learning at her own pace," right. "She is doing the best that she can "and going as fast as she can."

- I love the not yet, too. You used that, or you mentioned that as a different choice for food refusal, but I use that a lot to describe what a child is not yet doing, or next steps.

- Great point. Hypersensitive, I think the occupational therapists in the world are at fault for this one, right, because instead of saying hypersensitive, we might just say that they're sensitive. That feels a little bit more gentle. We might say a child is cautious, or they're being careful, or they're being protective, and for a lot of kids who have gone through hard things, hospitalizations, have experienced trauma, those children have every right to be cautious and to be protective of themselves.

- Absolutely.

- Then the last one that we have is behavioral, right. I really, really don't like this word when people, professionals, people with titles are saying that kids are being behavioral, because I think it sort of, it makes us as adults judge kids and make us think that kids are intentionally doing these things. But you know, we know that kids behaviors are communication, so we can identify those behaviors as communication, we can say

things like, you know, "She's having a strong reaction," or we can ask parents, "What do you think she's trying to tell us "when she throws the food, "or when she turns her head away," right. Behavioral observations can really open the door to better conversations and better understanding of kids and parents. So the last thing we wanna just highlight when we think about judgment is food, and we know that there's lots and lots and lots of reasons why a parent might choose to feed their child a certain food. So we know that health beliefs might play into that, cultural beliefs, and then religious beliefs might play into that as well. So parents do what works. I think we've really highlighted this in some of our prior slides, but parents are doing their best to make sure their kids eat, and again, sometimes parents might be doing these things and we get a little judgmental, but you know, when parents offer their kids foods in the same way, it ensures that that child is gonna eat, right, or have a predictable outcome that that parent wants. Parents might feed kids separately. I know that as therapists, we get really excited about family mealtimes, but sometimes it's just easier for a parent to feed a child on their own, by themselves. We discussed the use of screens, and that one thing we really haven't described but is hard for a lot of families is the idea of eating out, right. Parents know in a lot of situations when they offer foods, familiar foods in the same way, without eating out or in a different place, that they have a predictable outcome.

So parents are just trying their best to do what works. So another aspect of judgment that we wanna bring up is how do we talk about parents? How do we talk about parents as, when we're professionals, talking to each other, maybe when the parent is not there? I think it can be really easy for us to judge parents and judge the things that we're doing as we're making these remarks as professionals. So I think that it might make sense to us, for us to say, okay, instead of saying, "What's wrong with you," or pointing out those things that are wrong with parents, we might think, what happened to them? So I think that really changes the discussion that we have with other professionals. And then as we're talking to parents themselves, we might say, "What's

been your experience?" We wanna ask really good questions so that we can understand what a parent has gone through so we can really do our best to help them in that moment.

- Yeah, and you know, we're gonna talk a lot about teams in the last portion of the webinar series, but I think it's important to mention as we're talking about how we think about and discuss parents is that we are, we're human, right, we're emotional. We have emotional responses to our interactions and when things go well, we're happy, when they don't go well, we're frustrated, but I think, how do we talk about parents really starts with how do we think about parents, and that when we are feeling those emotional responses, we can even stop ourselves and reframe the language that we're using as we think about parents, reframe the language we're using in our discussions with other members of the team, 'cause that really contributes to the tone of how the team works together and with families, you know. So that's a great point. So we're gonna wrap up this portion of the series by showing you a case study. We'd like you to meet Isabelle. We're sharing this case study with you to demonstrate a lot of the ideas and themes that we've mentioned along the way. So Isabelle was born at 37 weeks. She was small for gestational age, and it's important to know that the placenta, her mom's placenta began failing at 36 weeks.

So think about that in terms of just the idea of choosing our language carefully, right. Isabelle's mom had already been told that she wasn't nourishing her baby optimally. Isabelle had a diagnosis of moderate pulmonary valve stenosis that was being monitored, and she was pretty sick for about a week early on. So her parent's primary concerns was that, were that she had difficult with feeding, both at the breast and with bottle-feeding. She would fall asleep, she, her mom produced a lot of breast milk. She had a dream that she would, or an expectation that she would breastfeed Isabelle as long as Isabelle wanted to do so, and that wasn't working. So her mom was pumping and offering expressed breast milk, which was incredibly challenging considering that

Isabelle had an older brother at home, and both of her parents worked full-time. So it just wasn't that easy experience that she expected, and Isabelle was growing slowly, as a lot of children with small, with a diagnosis of SGA do initially. So Isabelle's family went through multiple assessments. I won't go through specifically all the different recommendations, but we wanted to list some of those here so you understand that this family received a lot of information from professionals. She saw two speech language pathologists. One of them was also an IBCLC. She saw another IBCLC separately, and was just given all different types of recommendations and just was overwhelmed by the need to sort through that and decide what was best for her family. They also had a consultation with a registered dietician who took a look at the caloric intake, and made some recommendations from that perspective. So her parent's goals were, they really communicated to me in some of our earliest conversations that they felt stress with all of the multiple providers that were involved and the different advice, and her mom specifically requested one team, one plan, and one specialist to address each area of concern in her care. So she was also getting physical therapy. So there were multiple things they were working on. Her mother was exhausted from pumping and breastfeeding, and she had made a decision that she wanted to use up her supply of frozen milk and transition to formula.

I just wanna point out that this is one point. We are trained to support and encourage breastfeeding for a number of reasons. I had to really put aside my strong inclination to recommend or problem-solve ways that she could keep on going, but I had to really listen to her, hear what she said about her emotion experience, and respect the choices that she made. Then she wanted to support Isabelle's endurance for feeding so she could get through the feedings, and take that volume that other professionals had recommended. Some of the recommendations we made were some changes in positioning, changes in the flow of the breast milk and formula, by changing the nipple, pacing Isabelle if she needed it. We were considering a swallow study because she had some mild congestion. So here's what happened. Over time, her congestion

resolved, the compensatory strategies worked really well. So her mom practiced, we talked together about what felt comfortable for her as she was implementing some of the strategies that we had chosen together. Isabelle's intake slowly increased over time. She had more days where she was able to eat more than days where her parents were really worried because she would maybe fall asleep more frequently. She transitioned to formula, and then at five months, things changed. Isabelle's parents were wonderful at incorporating her in family mealtimes, and she started to show a significant and persistent interest in solids, so her parent's goals changed. They wanted to know, how can we best support her at the table? They wanted to plan slow introductions of taste experiences, and they were worried about what the right way to do that was. So we showed you a video in one of the prior modules of Isabelle eating baked apples with her dad. We wanted to remind you of that, but what we really wanna do is talk to you about how the process went after that point. So with continued exposure to solids at mealtimes, and watching her older brother eat, Isabelle really enjoyed sitting on her parent's lap versus the highchair. She was a little small for that highchair and it didn't support her well enough. She continued to do what she was doing in this picture, which was just lunging and reaching for pieces of food, and you know, her parents offered her purees, because they thought they should, and she showed a clear preference that she preferred finger foods. So as we wrap up, I'm gonna show with you a video where Isabelle's mother communicates some of her own emotional experiences. So we'll just get right started with this.

- I'm sorry.

- So our biggest thing is just that we get a little bit on edge when she has really poor feedings with the bottle, but, and I think any parent in our situation who has to be so focused on her intake would be concerned,

- [Stephanie] Yes.

- the way we've been intermittently concerned. So she didn't gain as much as they wanted her to gain over the course of two weeks or a week or whatever, we're sort of like, come on. She, it's more of like the principle of the matter, where we are, aye, yeah, this is so yummy, where we're just like, she's, we can't force her to eat.

- [Stephanie] Right.

- She eats what she eats.

- Right, and that hurts.

- She's growing on her own curve, so we're just, not frustrated completely, but just like, okay, when is this gonna be enough for her? When are people gonna finally say, this is just who Isabelle is, we will accept her as is, instead of this nonsense.

- So I wanna just

- I'm curious to see how she does.

- and just reflect, my job in this session, this portion of this session was to really listen and let her mom communicate her frustration, and you can hear in her voice how those initial goals of a specific volume at each feeding, you know, even though Isabelle was doing so well with finger foods, that pressure stayed with her parents. So we wanna show you the last part of this clip where you can see her mom really reading her cues and being just so responsive. That's such a good idea, 'cause it's so soft.

- Well, and Ryan loves it. I ate a ton of it in my pregnancies, with both kids.

- With both kids?

- Yeah, we're big fish people in our house, so she just, she'll probably like it, I would assume. And I, do you wanna hold it with your hand, or you want Mommy to help? So, see what I, she would much rather, since she's teething, I think, eat this kind of stuff than the purees.

- She really likes this.

- Uh-uh.

- And I love how you're making, you're offering her just enough assistance.

- Yeah, I'm not hardly, I don't, I want her to learn, this is her domain, not mine. I don't ever want my kids to feel like I'm forcing them to eat food, so.

- Has she started picking those up yet, or not yet?

- We'll see what happens. I mean, the effort's there.

- The hands, the hands, they're trying.

- [Mom] She'll take it.

- Oh look, I love that.

- [Mom] There you go.

- [Stephanie] With a little help.

- Good job, Izzy, yeah, it's so yummy. We'll try again. We're working on our coordination.

- So I just love wrapping up with that clip. In the beginning it was hard to hear, but her mom wanted to try salmon. She just knew that it would go well, so we wanted to highlight that after lots of conversations and treatment sessions, this was a mom who was really confident, confident in her skills, confident in her ability to support Isabelle, confident in her ability to read Isabelle's cues, support her preferences, and she understood that this was a process over time. So at the point at which this video was taken, we had worked a long time, and we're really doing a lot more celebrating now. So that is just one way that a strong professional-parent relationship can support parents on this journey.

- Stephanie, I'm so glad you shared that example, and I think one of the things that your example highlights is that it can be really, really just gratifying and fun as a professional when you can help parents and kids come together, when you can help parents see that progress, because you're really journeying with families from a place of distress, a place of pain, a place of grief, to a place of kind of typical development and normal eating, and normal eating just has the potential to be so enjoyable. So we hope that everyone listening really enjoyed this. We hope that you learned some things you can use in your practice, and we are looking forward to seeing you again during Talk Four, where we're gonna talk more about intervention, and we're also gonna talk about teams. So thanks so much, and we'll see ya soon.

- [Stephanie] See you soon.

- [Fawn] Thank you so much for a great Part Three. Looking forward to the next part, thanks everyone.