Introduction to Feeding Therapy: General Guidelines and Treating the "Picky Eater"

WSHA Convention 2015
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1. Overview of Today's Presentation
   a. Viewing the "Whole Child" to teach them to eat or expand their food repertoire
   b. General tips and strategies, based on the reasons why kids don't eat
   c. Developmental/sensory techniques
      i. Desensitization, play activities, positive reinforcements, and parent/home involvement.
   d. Insurance coverage/Appealing denials.
   e. Disclaimers:
      i. There is no way that I can fit everything into a two hour presentation, but my hopes are to give some of the tools and enough background knowledge, so you can identify areas of need and seek the help of another professionals
      ii. Frequently, there is little you can do to help the feeding (if the other areas aren't treated)
      iii. Please don't reproduce/copy the outline. See handouts in the back of your packet that you can feel free to copy and give to parents/colleagues. Those are labeled as such.
      iv. Confidentiality- parents have given written permission to present these videos, but because they are local and recent videos, please maintain HIPPA privacy policies.

2. My Background

3. MIND MAP OF WHOLE CHILD

   Behaviors
   • What we see the child doing - what we do
   • Neg vs. positive rein.

   Oral motor skills
   • Strength
   • Coordination
   • Range of motion
   • Oral Sensitivity

   GI
   • Reflux
   • Food Intolerances
   • Motility
   • Constipation

   Sensory Processing

   Developmental

   Feeding/Eating

   Postural Support/Seating and Positioning

   Developmental Progression of Textures

   Motor Planning
4. The Whole Child
   a. **Feeding** (What we see day to day, putting the food in your mouth, chewing, swallowing or NOT)
   b. **Behaviors**
      i. Infants:  
         Colic, gagging, eating around the clock, snacking, painful latch, arching, only eating when they’re sleeping (REFLUX), sleep issues, pooping issues (what’s normal…we talk about poop all day long)
      ii. Older Children:  
         Refusal, seeking control, temper tantrums, throwing food, acting distracted, liquid diet (only milk, yet that’s probably making them sick.), cup refusal…
      iii. Parents (or you) need to convey to the Pediatrician that this is beyond normal, get data if necessary, because that is how you get to real issue(s) beyond the feeding disorder. Parents open up far more to therapists then pediatricians…and pediatricians know this.
   c. **Oral Motor** (Beyond puduku)
      i. ASHA statement on Oral motor and where it all started.
      ii. Don’t do oral motor alone in a treatment session
      iii. Always do functional activity after OM input
      iv. Children will not progress if they do not have the oral motor skills to feel safe to eat/swallow
      v. Hyper active gag reflex
         i. Weak jaw, tongue and posterior cheek (protective mechanism)
         ii. Severe GI/reflux issues or history of such
      vi. “Mother Care Screener”- evidenced base screener developed by Debora Beckman
         a. Chewing 10/20
         b. Tongue Midblade Elevation (very common kids with reflux won’t do it)
         c. Gum Massage and tongue tilt
         d. Cheek contraction
      vii. Look at chewing in older kids, Front of their mouth, back lateral (video)
      viii. Let’s Try some things (gloves available)
         a. Cheerios vs. puffs
         b. Gum
         c. Straw
         d. Imagine pouches…feeding therapists’ nightmare!
      ix. Oral Motor Tricks and Tips
         a. Flipping goldfish and puffs
         b. *stick shaped toys, fingers, soothe pacifiers, veggie straws, pea crisps, cheetos (if dairy is ok)
         c. Oral play in younger children
         d. Hard palate massage
         e. Gum massage and teeth brushing routines
         f. Increase activations, by increasing sensory input (start with least amount of assistance)
      i. Change temperature, texture, flavor, vibration, add motion
   x. Common misconceptions
      a. Maybe this is just typical, maybe they will outgrow this
      b. Remember, “we don’t treat typical”, Beckman 2014
   xi. Causes
      a. Birth trauma
      b. Intrauterine positioning …didn’t practice in the womb
   xii. Other oral motor points
      a. Oral motor therapy vs oral motor play
      b. Gives us the reasons beyond what we’re seeing (e.g. clamping, leaking milk, etc)
      c. **If properly trained, and you can speak comfortably about range of motion, coordination, durational strength, you have a getter chance of getting it covered and demonstrating medical necessity and progress with therapy.**
      d. If you’re not getting responses you would expect, if you’re plateauing in therapy, then you need to seek the advice or consult of someone trained in Oral Motor Therapy.
      e. Skype consults, or office consults, and Beckman gives us permission to train other people as long as they are given hands on training and guidance
      f. Debora Beckman (12/17/2014)
1. “As a therapist trained in Beckman Oral Motor Assessment and Intervention, you provide the assessment, determine the plan for intervention and implement the interventions using any and all team members that are approved by the family to participate in the daily carryover of the intervention strategies. The therapist trains whomever is providing the interventions and revises the program as needed. The best changes for function occur if there is daily follow up with the interventions provided no more than 1 to 3 repetitions, no more than 3 to 5 times a day to insure activation of the muscles without fatigue. Greater opportunity for movement means greater opportunity for change in muscle function. It takes a village! Everyone can participate to bring change about, under the direction of the therapist. If you have any other questions, I am happy to answer them. Keep up the good work.”

d. Gastrointestinal
  ii. Reflux
    1. Signs and symptoms
    2. Beckman handouts
       a. Major signs:
          i. "Colic" un-calmable" babies…minus witching hour
          ii. Noises – inspiratory strider, actual reflux, grunting
          iii. Arching, turning, extensor preference
          iv. Non-stop eaters vs. snackers (1-2 oz 11 times a day)
          v. No signs of hunger (up to 8 hours stretches, body turns hunger cues off…”fire together wire together”)
          vi. Fussy during or after feedings
          vii. Bottle or breast refusal
          viii. Uncoordinated Suck:Swallow:Breath Pattern, that isn’t improved by other interventions
    3. From my clinical experience: Number one cause of feeding challenges in newborns is either OM, Reflux, but usually both
    4. Most frequent cause of Reflux (Dairy, Low tone, or Both)
       a. 2 weeks to get out of mom’s milk supply and another 2 weeks to get out of baby’s system (however, generally see some relief sooner)
    5. Tips on feeding reflux babies,
       a. Feeding at an incline on left side, helps stomach emptying
       b. Pacifier in between feedings (helps with peristaltic wave, easy to keep down if still sucking)
       c. Don’t over feed, frequent small feedings (feeding more will not help sleep better)
       d. Quiet calm setting, similar routine (e.g. setting, chair, blanket, song, low lighting, rocking, walking (only if necessary)
          i. KEEP IN MIND: Shouldn’t need this if gut is managed, if gut isn’t managed feeding will eventually plateau and other skills will regress
       e. Oatmeal-only when recommended by GI doctor… only for very specific children
       f. Avoid stomach compression
       g. Ask parents, ”How does the baby preferred to be held?”
          i. Over the shoulder
          ii. Inclined on the back
          iii. Babies have a way of letting parents know what is most comfortable
       h. Hold up for 20 minutes or in a bouncy seat after eating without stomach compression
       i. Roll for diaper changes, prop of legs of crib and/or changing table
       j. Don’t do “cry it out” with these babies, unless you are certain symptoms are under control!
       k. Provide a lot of calming sensory input for these babies, need to undo the sensory damage… “Do whatever it takes to keep them calm and happy”
  i. Medications
   1. Histamine-2 (H2) Blockers for Heartburn and Reflux (e.g. Ranitidine aka Zantac)- Histamine stimulates acid production, especially after meals, so H2 blockers are best taken 20 minutes before meals to block acid production.
      a. Families have to very closely monitor weight and check in with providers regarding dosage. May not think that a small increase (e.g. .3 ml will make a big difference, but it can). Need to stay on top of dosing to prevent regression with dosing.
2. **Proton Pump Inhibitors (PPIs)** for Heartburn and Reflux (e.g. Omeprazole aka Prilosec, Zegerid) block acid production and for a longer period. Do not need to up the dosage as much, generally with older babies, and generally after they fail a Zantac trial. ([mayoclinic.org](http://mayoclinic.org)).

3. Keep in Mind: Current recommendations for Reflux management change regularly

   **ii. Tips on Meds for Parents**

   1. Do not stop meds because they stop throwing up, especially if they are still having difficulty eating.

   2. **Many** babies with GERD don’t “spit up”

   3. Even “Happy” babies have GERD

   4. Do not make changes to medications against/without Pediatrician’s advice

   5. Make sure dosage is current

   6. Don’t be afraid of meds, can be very helpful in the short term if used properly while you figure out other issues (e.g. feeding skills, food intolerances).

   **iii. Allergies vs. Food Intolerances**

   1. Straight-forward vs. Not

   2. Cycle of malnutrition, behavior and picky eating

   3. Know parents’/family’s food intolerances...highly hereditary

   4. **Dairy Intolerance** (# 1 cause of reflux, 2 weeks out of mom’s system, 2 weeks out of babies system)

   5. Intolerance Cycle of Eating: gets enough in system, then stops eating, feels better and cycle repeats….

   6. Major 8 (Dairy, Wheat, Soy, Nuts, Shellfish, Peanuts, Corn, Fish)

      a. Other sensitivities: Sugar, Fructose

   **Know the signs of reflux... you may be the first to identify!**

   **iv. Nutrition:**

   1. Something needs to be taken out

   2. Something needs to be added

   3. Hydration?

   4. Ask about the poo!

      a. Often what can be generalized as normal for typical eaters, is not “normal” for our children (i.e. feeding and nutrition gets better, and stools normalize)

   5. Consult with Nutritionist (e.g. Outpost Consult)

   6. MD

   7. Naturopaths


   9. Not our job to diagnose, it’s our job to help the parent and other professionals consider nutritional issues, observe and problem solve.

   10. Only true way to know is “clinical trials”

   11. Food is an emotional topic for people (e.g. overload of information, personal shame, long history with food)

   **e. Sensory Processing Disorder**

   1. Eating is the most sensory involved activity that children do, it involves all of the major sensory systems and they are changing with every bite

   2. **The Eight Sensory Systems...**

      a. Visual

      b. Auditory

      c. Tactile

      d. Olfactory

      e. Gustatory

      f. Vestibular

      g. Proprioception

      h. Interoception (STAR Center/SPD Foundation.... [http://spdstar.org/](http://spdstar.org/))

   3. Checklists/Screeners (provide to all families at initial intake)


      i. Broken down by type and over/under

      b. [http://spdfoundation.net/library/checklist.html](http://spdfoundation.net/library/checklist.html)
i. Infant to adult screener
   i. Very comprehensive, broken down by area

4. Websites
   a. SPD Foundation
   b. Sensory Processing Disorder.com
   c. Star Center/SPD Foundation - great website with resources and links to webinars with leading specialists

5. Pinterest Boards
7. Continuing education courses (Sensory Processing in Speech/Language Therapy)
   ii. Red light, green light (trying to create a yellow light)
   iii. Important that we refer out when necessary and as early as possible. Give a checklist in the initial paperwork for all children.
   iv. Note: Sensory therapy can make them significantly better, however “behavior” plans, nutrition… needs to take them the rest of the way.

f. Cognitive/Developmental Level:
   i. How to reach this individual child? (language, motor play, pretend play, music, imitation, tools, routine, verbal cues, sensory or core prep)

   1-2 years (Many picky eating stories start here)
   - Appetite drops as growth slows
   - Learns to drink from cup, usually weaned
   - May cut back to 2 cups of milk a day
   - Likes to feed self but likely needs help
   - Copies others and will mainly eat family foods
   - When cutting teeth, may have difficulty chewing
   - Has acute taste buds and can detect slight differences in foods
   - Is developing likes and dislikes; likes sweets
   - Likes to touch and play with food, responds to food texture
   - Learns to say no and be more independent

2-3 years
   - Improved muscle control, can use spoon and fork
   - Desserts/sweets desired and asked for
   - Will be willing to wait a bit for requests to be filled
   - Usually will eat raw veggies, but may refuse salads
   - Green veggies become more acceptable

4-5 years
   - May return to food jags or go on food strikes
   - Is influenced by others (i.e. children, tv ads, teachers)
   - Likes plain cooking and foods separated on plate
   - Dislikes most mixed food dishes and gravies
   - By age five, often has fewer demands and will accept available food
   - Appetite is gradually decreasing

8. Progression of food textures (see handout in back)

h. Core/Postural Support
   i. Older kids
      1. 90-90-90

   ii. Infants
      1. Bouncy seat
      2. Semi-upright position
      3. Slight pelvic tilt with knees slightly higher than rear
      4. Feet supported
      5. May need side supports
      6. No Bumbo chairs for feeding
      7. Place chair at eye-level

   iii. Seating and positioning (SO IMPORTANT)
      1. Baby Bouncy Seat
      2. Slightly reclined infant seat
3. Foot supports or ankle waits
4. Travel Booster Seats
5. Clip-on Highchairs
6. Tripp Trapp/Keekaroo Chairs
7. Bolster child’s hips
8. No slip-shelf liner

i. **Motor Planning**
   i. The ability to **conceive, plan, and carry out** a skilled (including fine-tuned adjustments), non-habitual motor act in the correct sequence from beginning to end. Incoming sensory stimuli must be correctly integrated in order to form the basis for appropriate, coordinated motor responses ([http://nspt4kids.com/healthtopics-and-conditions-database/motor-planning/](http://nspt4kids.com/healthtopics-and-conditions-database/motor-planning/))
   ii. Most of early motor planning is learned through eating and food exploration
      1. Just another reason to let kids play with their food
   iii. Eating an Oreo cookie, climbing into a chair, doing a puzzle

j. **Mental Health/Trauma**
   i. *We wouldn’t try and do the job of an OT, PT, MD, we shouldn't do the job of a Family Therapist*
      1. Start the conversation early
      2. “No-Drama discipline”
         a. Upstairs Brain vs. Downstairs Brain
      3. Relate to the child’s “brain” to reduce the mental health stigma associated with counseling
         a. Stress this is a normal brain reaction to child’s history (e.g. learned behavior)
   ii. **Child**
      1. Early Trauma, reflux, syringe force feeding, traumatic choking incident, sensory processing
         that leads to anxiety/behavior/control seeking
   iii. **Parents**
      1. Frequently parents need to attend “reprocessing” therapy to overcome anxiety of mealtime
         and child’s behavior
         a. Works best when therapist will work with parent and child to manage behaviors and anxiety.
            i. Be very careful about using the word “Behavior”…makes it seem intentional or volitional on the child’s part
         b. Parents are “hard-wired” to feed children—very traumatic when they can’t, especially
            if weight is an issue
         c. Can cause a lot of worry and “battling” later
         d. Can bring out underlying anxiety or trauma that was always there and possibly
            suppressed or never processed (e.g. How the Parent was parented in the past)
         e. People often assume parents’ anxiety is causing feeding issues in child (very rarely).
            Studies show, when child eats, parents’ anxieties go down.
         f. Very difficult for parents to feel “emotionally grounded” when child is not thriving,
            FTT, etc.
         g. “No Drama Discipline” by Daniel J. Siegel and Tina Payne Bryson
         h. Video tape home meals if not progressing at home, go through and provide feedback
            with parents
         i. Again, set ethical timelines
   iv. **Negative reinforcements**
      a. Yelling
      b. Threatening
      c. Pushing
      d. Punishing
      e. Shaming, isolating
      f. “Conflict within the child’s brain”, when parents force feed—Daniel Seigel
   v. A different perspective on the “Behavioral Approach”
      i. Always meet the child where he/she is functioning
         1. Try and move beyond one or two steps
         2. Watch for signs of distress and back down
         3. Every day will be different…still meet child where s/he is
         4. Tone of voice/emotion behind interactions
            a. Children and especially children with SPD are highly sensitive to adults emotions
            b. When adults show stress, it makes children feel unsafe
            c. “Testing”
i. We need to pass the test

k. **Build your “Whole Child” Feeding Team**
   i. Talk with other professionals and see who is the best in your area, call and schedule a lunch
   ii. Start the conversation early regarding the need for a whole team approach; this makes referring easier later on when necessary
   1. Pediatrician
   2. GI Doctor
   3. OT
      a. Specialized in SI, posture/ribcage, motor planning
   4. Lactation Consultant
   5. Family Counselor/Psychotherapist
      a. Experienced in Trauma
      b. Parenting Skills
      c. Will work with family and parents individually
   6. PT
   7. Allergy Doctor
   8. Nutritionist/Dietitian – experienced with food intolerances and FTT, doesn’t just focus on obesity
   9. ENT-tonsils and adenoids interfering with swallowing
   10. Naturopath/Acupuncturist?
      a. Can be very helpful with food insensitivities
      b. Be very confident in their services before you refer a patient

5. **Treating the “Picky Eater”:**
   a. **PICKY VS. Problem Feeder** – Kay Toomey
      i. Typical “Picky”…”Children are not naturally picky!
         1. I don’t like apples for a day
         2. I don’t like meat for a few weeks
         3. Tends to happen with major cognitive developmental shifts (1 year, 2 year, 3 years), illnesses, etc. These should pass after a few weeks.
         4. Similar to temper tantrums. Look at
            a. Frequency?
            b. Duration?
            c. Intensity?
      5. Picky (see SOS handout)
      6. Problem
         a. **Both** of these kids need services, one will progress much faster and probably need less outside interventions
   b. **Prevention** - FIRST…Where do Picky Eaters come from?
      i. Oral motor play
         1. Stick Shaped toys increase strength, coordination, grating, durational strength (cheeks, jaw, tongue, lips, reduce gag reflex)
         2. Sophie vs. Sophie
         3. Hard Munchables (VERY Closely Monitor…do not leave for a second!)
         4. Playing in babies mouth (not natural but so necessary)
         5. Letting them chew on safe toys under supervision, that’s how they grade strength of chew
         6. Naturally reduce gag reflux
ii. Slowing down introduction (bring in food textures)
   1. Developmental Food Progression (See Handout)

iii. Spoon play (video)
   1. Start at 4 months (as soon as can bring an object to mouth) in bouncy seat during dinner and
do spoon play, scant taste or whiff of what parents are eating (not dairy, not wheat preferred).

iv. Strategies for introducing purees:
   1. No grains for first food
   2. Don’t introduce new foods (especially major 8 when sick)
   3. Start small scant amount on spoon
   4. Start with just a teaspoon to lower expectations
   5. Only do when baby is happy and ready, okay to skip a day or two
   6. Downward pressure on tongue
   7. Start at lips, gum, tip of tongue, to mid-blade
   8. Slowdown wait and watch for babies cues
   9. “Check your face”

v. No such thing as “junk food”

vi. Seating and positioning (SO IMPORTANT)
   1. Especially in children with weak cores, low tone, and even mild proprioception issues

   c. Play and Interaction with Food
      i. Play is the basis of learning
      ii. We teach young children to do everything else through play (e.g. language, gross/fine motor)
      iii. Teach children how to slowly interact with food, so they can independently use these skills on their
          own.
          1. Child will eventually learn to touch, then take a small lick of new foods, tasting is NOT the first
             step to interacting with food!
          2. If you can’t get them to eat it, just focus on play an interaction

   d. Modeling
      i. Children learn to eat through modeling
      ii. Children by nature want to please and imitate
          1. if they have the skills of imitation.. sometimes you need to teach this first
          2. if they aren’t able to imitate, back down the level of imitation
      iii. Children will often feel safer eating off our plate or eating when food is placed off to the side of their
          plates.
      iv. May model you, but with a safer food (sign of stress)
      v. Parents and therapists need to eat the foods they want the children to eat
          1. Chicken nuggets to broccoli
          2. Unrealistic that children will be less “picky” then parents
          3. Wonder Bread vs. Ezekiel Bread

   e. Therapy Meals
      i. Set up the table
      ii. Look at all the foods in the containers (avoid containers they come in...may lead to rigidity)
      iii. “SAFE FOOD”....Start with really easy preferred food will usually be dry, crunchy, salty
          1. Keep that food available throughout the session
          2. Children will go back to safe foods when pushed too far
          3. Therapist can go back to safe foods to re-engage the child in play scheme
          4. Can use safe foods to interact with new foods, or change textures of new foods
             a. Crunching up chips or Doritos ® with lunch meat
             b. Adding granola to yogurt with lumps of fruit
             c. Adding crushed crackers to vegetable soup, gold fish to tomato soup
          5. Child can go back to it, when they get too stressed
      iv. Save sweet things for the end (sugar turns off appetite)
      v. Don’t let the Child get too stressed
         1. Try to back down with the interaction before they get overwhelmed and verbally refuse
         2. Adrenaline turns off appetite
         3. Remember “Neurons that fire together, wire together,” so we don’t want to get them into “fight
             or flight”
      vi. Try to end on a high note
      vii. Teach a cleanup routine
      viii. Some kids may need a visual schedule
      ix. Stuffing (Video of 15 month Male)- Generally due to decreases sensory awareness and decreases
          oral motor strength (i.e. can feel and can’t control it)
1. Ration foods to avoid over stuffing  
   a. Can be very challenging as they generally get frustrated  
2. Give tastes of sour or cold on Nuk® brush (safely and gently)  
3. If you feel the child is safe, you can give small sips of water through a straw, to help clear  
4. Alternate textures (chewy, crunchy, chewy) increase awareness  
5. Change the texture of the food, to increase bolus formation (e.g. adding pretzels to cheese stick)  
6. Do a lot of language around size, TOO big, TOO small, JUST right!  
7. Teach everyone that it’s good to spit it out…difficult motor task  
x. Model chewing then spitting to show how well chewed the food was for older children  
   1. Chew a raw carrot 10, 15, 20, 25, 30 times. “Get it to apple sauce”  
xi. Watch for “Hard Swallows”  

xii. Selecting food  
   1. Have parents bring food, you know this is food that is a priority (already in the house).  
   2. Alternate between safe, and non-preferred foods  
   3. Various colors, textures  
   4. Various difficulties for the child  
      a. Don’t expect same interaction with each food  
   5. Goal to include at least one fruit, veggie, protein, new carb, puree  
xiii. Games/Play to increase interacting with or eating new foods (adjust as needed)  
   1. Peek-a-boo  
   2. Hold it in your palm (works very well for younger children)  
   3. Hold it in your palm and close your eye…where did it go?  
   4. Talk about what food is doing in your hands or in your mouth  
   5. Pretend Play  
   6. Magic Play  
   7. 5 little monkeys (adjust the interaction with each monkey)  
   8. Itsy Bitsy Spider  
   9. Swords and Princess Wands  
   10. Put on Makeup  
   11. Label body parts  
   12. 1-2-3 Copy Me and take turns  
   13. Blowing it away  
   14. Kissing  
   15. Where did I hide it (e.g. under my tongue)...they’ll surprise you with in “In my tummy!”  
   16. Put the food in clear containers, clear plastic cup or “microscope”  
   17. Use cooking tools to increase interaction with really challenging foods (slap chops, cookie cutters, empanada presses, Playdoh® tools,  
   18. Smoothies- Take ‘em or leave ‘em  
   19. Sculptures  
   20. Tear, smash, break, tug of war with hands or mouth  
   21. Counting chews (whom ever gets to the most before it’s gone wins  
   22. Closing your eyes and listening for the crunch  
   23. Let them take the lead and take turns, often they will surprise you  
   24. If you do ________, it might make me __________ (e.g. sneeze, hiccup, fall asleep)  
   25. Rolling food up arm and singing a song  
   26. Eating like a dog  
   27. Birdie bites off mom/dad’s hand  
   28. Eating off your knees or back of hand  
   29. Balancing food on head  
   30. Staring contests  
   31. Biting off pieces of food that’s held in parent’s mouth  
      a. Keep in mind the game should be at the appropriate “step”  
      b. One game may work on day and not the next, so use a variety of games  
      c. Games should always lead to eating and not distract from eating  
   32. Make sure child is doing some actually learning, not pushing self quickly (e.g. TV)  
      a. Slow down your play to make those connections  

f. Let’s Talk About It!  
i. “Upstairs and Downstairs Brain” from “No-Drama Discipline”  
   1. Talk about shape, numbers, color, texture, size, compare, what it does when you break it in your hands, flavor
a. Keeping in mind, many times the child’s senses are giving them an incorrect signal, don’t argue just re-educate
b. Try to get the children not to use “rude” words about food (e.g. gross, yucky, don’t like)

**ii. Routine Phrases, Songs, and Games**
1. Will eat a food without realizing it…it’s like they are hypnotized
   a. Clean up
   b. Songs about eating (e.g. climbing up your arm) VIDEO
   c. Songs about food exploration (VIDEO)
   d. Bite and pull
   e. Front puppy teeth
   f. Strong Back Chompers
   g. Chew it up like a Cow
   h. Dot, Dot, Dot- fingertip exploration
   i. Dip, Dip
   j. Chew, Chew, Chew, Swallow with gestures
   k. Great for toddlers learning colors
   l. Wiggling

**g. Repeated positive experience...building neuro-connections**
   i. Neurons that “Fire together Wire Together” – No Drama Discipline
   ii. Be specific about how you reinforce and praise “I like how you touched the apple sauce with your tippie finger”
   iii. Takes many, many positive experiences to learn a new skill, and only one negative experience to extinguish it. (e.g. choking, yelling, force feeding)
   iv. Hearing the Piano Music - “No Drama Discipline”
      1. If parents cannot get to this place, they need to get to a family counselor, because there is very little you can do. This is not our specialty.
      2. Many times parents will need to go back and deal with previous issues before they are mentally “ready” to support a picky eater at home
         i. Keep this in mind as you are creating home programs

**h. NEVER Push**
   i. Parents will ask how far can I push? Not at all.
   ii. No: Pushing, Bribing, tricking, negotiating, etc.
      1. Bring it back to the example of teaching a child to crawl. We don’t yell or set ultimatums for infants to crawl.
      2. **Children doing the best they can, meet them where they are functioning**
         iii. Use rewards very carefully, and only if you feel the child **and parents** have all other necessary skills (oral motor, gut, emotional regulation).

**i. Key Principles of Sensory Integration Approach- Schaff, Rosanne C., and Lucy Jane Miller**
   i. “The Just Right Challenge”
      1. The Therapist creates playful activities with achievable challenges, the activities incorporate a challenge but the child is always successful.
         a. Building Neuro-connections for new skills and accepting new foods
         b. Can be a back and forth “dance” and it gets easier the more you practice
         c. Our challenge is not to get frustrated and “push”
   
**ii. The Adaptive Response**
1. The response to the Just Right Challenge, the child adapts their behavior with new and useful strategies, thus furthering development

**iii. Active Engagement**
1. The therapist artful creation of challenging, yet playful, sensory rich environments entice the child to participate in play; the methods of play incorporate new and advance abilities that increase the child’s repertoire of skills and processing (i.e. various levels of interacting with non-preferred foods).

**iv. Child Directed**
1. The therapist constantly observes the child’s behaviors and reads their behavioral cues, thus following the child’s lead or suggestions. The therapist uses the child’s cues (stressed? not imitating?) to create enticing, sensory rich activities. …*this is the challenge*.
   a. Generally we see where the child comes in, interacting with the food, and then try to get them to interact slightly farther, until we see signs of stress. Then back down, re-engage, and try again.
i. Turing away/Gaze aversion
ii. Gagging
iii. Hand splaying
iv. Lips splaying
v. Defiance
vi. Stops imitating/participate

vii. We try to stop before they verbally refuse

j. Don’ts of Feeding Therapy
i. Don’t push volume, variety leads to volume, can increase calories
ii. Avoid the one more bite (try clean up routine)
iii. Negative reinforcement leads to behavior issues and conflict in the family
iv. **AVOID:** No, Stop, don’t and Yes/No Questions, consequences, rewards (only under very close supervision), power struggles…just like in play therapy!
v. Learning to eat is a marathon not a sprint

vi. Red Flags of Feeding Websites:
1. Seems too easy
2. Too heavy on behavior
3. Too systematic/rigid/dogmatic
4. Too unrealistic (e.g. kale and steamed salmon vs. chicken nuggets)
5. Only focuses on one discipline (i.e. doesn’t consider the team)

vii. Avoid TV, toys, distractions during meals (not learning if brain is shut down from TV)
1. May need to wean off TV

k. Want to learn to eat all foods, not just work on gaining acceptance to all foods
i. Has to be across environments
ii. Can focus on a few of the family’s favorites/staples (e.g. eggs, rice)

l. Presentation (think about the sensory systems)
i. Simplify it
ii. Use utensils
   1. Cocktail forks—great for getting food to lateral back region of mouth!
   2. Toothpicks
iii. Change the shape
iv. Contain it (weighted ramekins)
   1. Avoid divided plates, leads to rigidity regarding food touching
   2. May need to teach “food touching”
      a. Still a Cheetos ® even if it has apple sauce on it
      b. Make “recipes”

v. Put it on a stick
vi. Space food out
vii. Dip it

viii. Cookie cutters
ix. Stamp sized bites
x. Clear/clutter free surfaces
   1. Throwing food…common complaint
      a. Too visually over stimulating….clearing your desk before you can work

xi. Young children will clear tray if it gets over stimulation
   1. Can teach to push back
   2. Can do it for them
   3. Then re-engage with one food at a time, one of each item, a few of each item
   4. Push plate away and place on table

xii. Condiments
   1. Put the favorite condiment on foods, so they can’t eat around it
   2. Use condiments to support food chains
   3. Use condiments to re-engage
   4. Use condiments to break food jags

m. Structure to family meals
i. Sensory prep (collaborate with OT and make it doable)—families meals can be really hectic, so do what you can to keep things realistic
ii. Sit down together…prerequisite
iii. Set table (easy level of interaction)
iv. Self-serve/Family Style
Every Meal:
1. Protein
2. Fruit and or Veggie
3. Carb
4. Fat
5. One preferred food

Water during and high calorie drink and dessert at the end
1. Important to drink water throughout the day
   a. Constipation
   b. Too much will cause filling up at meals and can decrease absorption of nutrients.

Engage in play toward the end of the meals (set a time to keep expectation slow) 5 mins

Sugar suppresses appetite, but great for bedtime snack, store calories

Know when to end the meal (is there still valuable eating/learning going on?)
1. Still working
2. Toddlers need to be reengaged (without nagging), because they get bored or distracted
   a. Look! You sandwich is a triangle
3. An older child who frequently seems distracted?
   a. Anxiety?
   b. GI?
      i. Constipation?
      ii. Intolerance?
      iii. Motility?
      iv. Remember, kids frequently can’t articulate GI symptoms
   c. Sensory?
   d. All of the above?

Clean up

Prerequisites to feeding therapy (i.e. setting the families up for success)
1. Sensory integration plan established
   1. Can focus on parent education, oral motor, and preferred food interaction while OT regulates
      SI system and sensory diet is in place
2. Proper seating (see seating and positioning)
3. Developmentally appropriate oral motor skills
   1. Otherwise meet child where he/she is with food textures they can manipulate, continue to
      focus on oral motor skills, language, play, etc.
4. May need to set small achievable goals until family is ready for more drastic changes to routine
   1. Brushing protocol
   2. Sitting down to dinner
   3. Play activity goals
   4. Recommend a calendar to set weakly goals
   5. Builds initial success for parents and child
   6. Stress that success is measured by meeting these goals, can look back at these goals and
      feel successful. Often difficult for parents to see big picture and remember when, parents of
      children with FTT live and die by each day if not each meal

Resources for more typical to picky eaters
2. “Food Chaining”
   1. Example
      a. McDonald’s ® chicken nugget, Tyson chicken nugget, dino chicken nuggets,
         homemade chicken nuggets, breaded chicken fingers, homemade chicken fingers,
         grilled chicken (similar sauces), breaded shrimp/fish nuggets, breaded veggies…
      b. McDonald’s ® French fries, other French fries similar texture and shape, Culver’s
         French fries, sweet potato fries, roasted carrots, sautéed carrots (similar sauce),

When kids get sick
1. All bets are off
2. Not uncommon to really regress or even stop eating all together
3. Generally takes about 1 week or even more to regain where they were
   1. Trust they have the skills to get back
4. If this is happening repeatedly, may need to refer out (e.g. GI, Allergist)
5. Teething- request permission from MD for parents to give Tylenol or Ibuprofen 20 mins before
   therapy
b. Family-approach
   i. Set up time for questions
   ii. Encourage parent to email (even if you can respond)
   iii. Review last session's learning objectives (even if it seems redundant)
   iv. Parents can keep a journal
   v. Give real time examples
   vi. Have them videotape a home meal
   vii. Teach and Reteach
   viii. Sometimes have to push for a second opinion
   ix. Set up an ethical timeline

6. Getting Reimbursement
   a. Know the codes
      i. Dysarthria-need background and evaluation to back this up
      ii. Oral-Phase Dysphagia- people have been hesitant to use this, but the definition is clear
      iii. Feeding disturbance
      iv. Facial Weakness
      v. Hypotonia
      vi. Tongue Tie
      vii. Failure to Thrive/Weight Disturbance
      viii. GERD
   b. Justification
      i. Not traditional “speech” Therapy
      ii. Habilitative vs. rehabilitative (Beckman, 2014)
      iii. Birth Injury- bruising at birth (slow or fast delivery)
      iv. Illness-Reflux, chronic otitis media, enlarged adenoids, congestions, anoxia at birth,
      v. Oral Motor is considered-neurological defect by insurance companies!
   c. Other strategies
      i. Be proactive and start with a report and a cover letter
      ii. Don’t hesitate to
         CC:Office of the Commissioner of Insurance
         125 South Webster Street
         Madison, Wisconsin 53703-3474
      iii. Why this is the most cost effective
      iv. What could happen if they don’t get therapy
   d. Template for appeal letter
      i. What you’re asking for
      ii. When the child was diagnosed
         1. Injury/Illness (GERD, adenoidectomy, birth trama)
      iii. Why this is the cheapest, fastest, least invasive form of intervention
         1. Hospitalization
         2. Inpatient rehab feeding program
         3. G-Tube
         4. Risk of aspiration

Other random notes:
• Don’t tell parents to introduce baby foods to gain weight… creates too much pressure, need to look at why they’re not
  gaining weight. Only do this when oral motor skills are typical and GI doctor/Pediatrician has a specific reason to do
  so.
• Introduce frozen hard munchables for teething…positive, comforting association with taste of veggies (only if
  confident parent will maintain strict supervision). Fire together-wire together, veggies are associated with soothing and
  pleasure
• Frozen or roasted veggies (e.g. peas, corn, green beans, carrots, are often easier to introduce than other preparations
• Introduce other nut butters and beans when possible…makes school lunches easier with an ever increase in allergies
• Baby lead weaning

Print from Web:
Parent handout on feeding-
http://lib.dr.iastate.edu/cgi/viewcontent.cgi?article=1035&context=extension_families_pubs
Helpful Readings:


Other Resources:

Beckman Oral Motor http://www.beckmanoralmotor.com/
SPD Foundation- great information and webinars on Sensory Processing Disorder
Tosa Speech Therapy, LLC –information, handouts, and videos for therapists and families www.tosaspeechtherapy.com
The Good Food Factory- Follow on Facebook, funny videos on cooking with kids and recipese

References:

### Developmental Progression of Food Texture

<table>
<thead>
<tr>
<th>Age</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-13/15 months</td>
<td><strong>breast/bottle</strong></td>
</tr>
<tr>
<td>5-6 months</td>
<td><strong>thin baby food cereals</strong> (thin out purees with breast milk or prepared formula)</td>
</tr>
<tr>
<td>5.5 months</td>
<td><strong>slightly thicker baby food cereals + thin baby food puree/stage 1</strong></td>
</tr>
<tr>
<td>6 months</td>
<td><strong>thin baby food puree/stage 1</strong></td>
</tr>
<tr>
<td>7 months</td>
<td><strong>thicker baby food cereals and thicker baby food smooth purees/stage 2</strong></td>
</tr>
<tr>
<td>8 months</td>
<td><strong>soft mashed table foods and table food smooth puree</strong> (important step to transitioning to table foods!) (munkin baby food mill) Baby food mill needs to make a smooth “mashed potato consistent,” needs to strain out all husks, skins. Babies can start to finger feed</td>
</tr>
<tr>
<td>9 months</td>
<td><strong>meltable hard solids</strong> (town house crackers, some biter biscuits, graham crackers, Gerber cereal squares, fruit loops, captain crunch, baby cookies, Gerber Yogurt melts, Gerber fruit and veggie melt and Gerber cheetos (now gluten and dairy free), Cheetos, puffy popcorn, frozen drops of apple sauce</td>
</tr>
<tr>
<td>10 months</td>
<td><strong>soft cubes</strong> (avocado, overcooked squash, kiwi, vegetable soup ingredients without the broth, Gerber Graduates fruits, boiled potatoes, peas, bananas, veggies that have been heavily steamed, frozen then thawed (e.g. carrots, sweet potatoes, baby red potatoes, canned peas, canned green beans, hulled beans, egg yolks</td>
</tr>
<tr>
<td>11 months</td>
<td><strong>soft mechanical single texture</strong> (fruit breads, muffins, soft small pastas, cubed lunch meat, thin deli meats in small rectangles, soft pasta or soft meat soups without the broth, soft pretzels, barley, scrambled eggs)</td>
</tr>
<tr>
<td>12 months</td>
<td><strong>mixed texture</strong>, soft mechanics/stage 3 (mac and cheese, microwavable children’s meals, soft chicken nuggets (not fast food), French fries, spaghetti, lasagna, sticky rice, <strong>beans</strong> (super food), lentils,</td>
</tr>
<tr>
<td>12-14 months</td>
<td>soft table foods in appropriate sizes and shapes</td>
</tr>
<tr>
<td>16-18</td>
<td>months hard mechanics (cheerios, thin pretzel sticks, ritz crackers, saltine crackers, pop tarts, most other chips, Fritos</td>
</tr>
<tr>
<td>2 years</td>
<td>Child should be able to tolerate all food textures given appropriate sizes and shapes</td>
</tr>
</tbody>
</table>
When people talk about feeding difficulties, they often try to put the children into one of two categories; those who have "organic" or "physical" problems and those who have "behavioral" problems. In our original work at Rose Medical Center in Denver, (and now SOS Feeding Solutions @ STAR) we find that dichotomizing children with feeding difficulties is not helpful. One reason is that there is an implication of blame in this system. We don't believe it is accurate or useful to support a blaming stance with children who won't eat. Second, these are not true pure categories because children with physical difficulties often develop "behavioral" problems after their attempts to eat don't go well (i.e. they learn to avoid eating), and children with "behavioral" eating difficulties develop physical disorders after having poor nutrition for a period of time. So, the first thing we need to do is to get rid of the notion of trying to force children into categories where they don't belong. Instead, we find it most helpful to think about children who won't eat as having had poor learning experiences with food.

Many people believe that eating is completely instinctual and that no matter what happens, a child will eat. This is another myth in the food world. Actually instincts only start the process, and that is if you are lucky enough not to have your instincts not interfered with by prematurity, a physical disorder, or disruptive procedures needed for survival. Eating is, in reality, a learned behavior. Just as children learn to eat, so can children be taught to not eat by the circumstances of their lives. But how does this learning take place?

Research shows that learning about food happens through two main ways. The first is when a connection is made in time between one natural event, behavior, or object (= stimulus) and another neutral stimulus. For example, we know that feeling sick to your stomach causes a physical reaction of appetite suppression. This is the natural event. If we consistently connect the feeling of being nauseous with a food (previously a neutral thing), pretty soon that food itself will make us sick. Drinking too much alcohol and then never being able to go near that drink again without an upset stomach is a firsthand experience that many people have had. Another example is, when someone is in pain or discomfort they try to escape or avoid that pain (natural event). If this pain is then paired over time with food, the person will learn to escape the eating situation. Gastroesophageal reflux (GER) is a good example of this type of learning.

The second way we learn is through reinforcement and punishment. Here are some examples of these types of learning about food:

Eating ---> followed by praise or imitation (= positive reinforcement)
        ---> leads to more eating
Refusing to eat ---> followed by lots of attention & interaction from parents
stressed about needing to have their children eat (= positive reinforcement)
----> more refusal

So you can see that positive reinforcement can cause more of an undesired
behavior, as well as increasing wanted behaviors!

Now, how about some punishment examples?

Eating ---> followed by choking and fear (= punishment) ---> less eating

Eating ---> followed by being yelled at (= punishment) ---> less eating

Punishment around food is very powerful. Booth (1990) showed that if the learned
reaction to food is negative, there is a physical effect of appetite suppression.
That is, if the learning about food is unpleasant, our bodies will turn off our
appetites. Also, Weingarten and Marten (1989) showed that if you make negative
connections to the cues to eating (e.g. sitting down at the table, the utensils you
use, the people present, the room where you eat), you will learn to avoid the
feeding situation completely. The power of punishment is why we do not support
force feeding, except in very special circumstances. We find that children who are
force fed may learn to eat some foods to avoid being punished; but that this is not
a normal way of eating (it is actually escape learning). In addition, often times
after the punishment is removed, the child stops eating again.

What about learning to eat new foods? This takes place through a process
of presenting the new food over and over again along with positive reinforcement
for ANY interaction with the food. Birch (1990) showed that it takes up to 10
repeated presentations of a new food with positive reinforcement before a child will
begin to eat that food regularly. Many people make the mistake of taking that first
rejection of a new food as the final word, but it is not.

It is important whenever we work with children who have feeding problems
to first figure out how they learned to not eat. Were they premature and
constantly had people sticking things in their face? Did they have pain every time
they ate? Were they always congested so that they could never breathe while
they were eating? Did they have motor problems so that it was hard to coordinate
eating and they were always frustrated? Do they have a sensory integration
disorder so that it is hard for them to understand all the different pieces to eating?
The reasons children learn to not eat are many and varied.

Because learning is the key factor here, it is also critical to always be
aware of what each feeding interaction may be teaching the child. By refusing to
eat certain foods ourselves, are we teaching our children to avoid those foods? By
never sitting down to a family meal are we preventing our child from having a rich
learning experience about food, in addition to missing an important teaching
opportunity? By giving a child a toy during a meal after they just refused to take a bite for us, haven't we just reinforced noncompliance? By yelling or forcing are we teaching them that eating is unpleasant (and turning off their appetite)? Although difficult, it is often helpful to have someone else watch us feed our child so that they can help us pick up on these subtle negative teachings.

So, how do we teach children to eat? The overall goal of all treatment with children who won't eat is to create a situation which positively reinforces normal, healthy eating patterns. There are five main categories of strategies:

Structure - having a routine to meal times, eating in the same room, at the same table, with the same utensils are all things which capitalize on the need for repetition in learning. The more you can make things about the meal the same, the easier it will be for the child to learn. In addition, the routine itself can help get the child primed and ready to eat. It is especially important with G-tube fed children to have approximately the following routine: 1. help with food preparation, 2. sit in high chair or at table with same utensils, 3. offer food and drink first, 4. as the child is almost done with the meal, start their bolus feeding while still in the chair with food on the tray. Many G-tube fed children are fed lying on their back in their bed. This is not a normal way of eating. Children fed like this learn that when they are hungry food comes out of nowhere without their effort, or they learn that they eat from the pump without using their mouths. We want these children to learn to connect the sensation of their stomachs being filled with food in their mouth. Even infants on tubes should be fed in a normal bottle or breast feeding position, preferably with a bottle or pacifier with formula or breast milk on it in their mouth.

Social modeling - one major way children learn to eat is through observation of others. Family meals are critical to providing children with multiple opportunities to learn about eating. This also means that we need to be very good role models. Over-emphasizing chewing with our mouths open and using exaggerated swallowing, helps children to understand about what to do with food. We need to be positive about our interactions with food. Because children love to imitate what we do, we need to not make faces or bad comments about food. If you are a poor eater, it may be difficult to help your child.

Positive reinforcement - so many times when we see children who won't eat, we find out that mealtimes have become an unhappy struggle for everybody. Meals need to be pleasant and enjoyable. Eat a normal family meal and wait to do any feeding programs until you are done with your food (but don't forget to keep a little food aside so you can be a good role model during the program time of the meal). During the meal, make sure that ANY interaction with the food is rewarded. Verbal praise is the best and most normal reinforcer. However, a smile, a touch, a cheer, clapping are all other options. The level of reward needs to be geared to each individual child. Also, remember that punishment can turn off a child's
appetite. Special feeding programs should be created only with the help of a qualified professional.

**Making foods manageable** - a common problem we see is a child being offered foods they really cannot manage to eat. Giving a 2 year old child with oral-motor problems a full hamburger, plus potato, plus vegetable on their tray is overwhelming, frustrating and defeating. Foods need to be in small, easily chewable bites or in long, thin strips that the child can easily hold. Also, the rule of thumb is to only present a child with a total of 3 foods on their plate at any one time. There should be 1 tablespoon per each year of your child's age of each of these 3 foods. With new foods, make the food less "new" by first introducing it to the child on the table only. Then you can put it on their plate. Remember, new foods need to be presented repeatedly with positive reinforcement from any interactions with the new food.

**Accessing cognitive skills** - because the skills for eating haven't come easy to children with feeding problems, they need to use their intelligence (cognitive abilities) to help themselves better manage the foods. This means that we need to teach them about the physical properties of the foods so that they will know how to make the foods work in their mouths. For example, banging a carrot stick on the table and talking about how hard it is teaches that the mouth and teeth will need to use hard pressure to break that food apart. Versus, a piece of string cheese which wiggles and is squishy will be somewhat chewy in the mouth. Versus a food such as yogurt is cold, wet and smooth and therefore can be just sucked down. We refer to this process as teaching children the "physics of food".

These recommendations are just a few of the many ways children can be helped to eat. Hopefully, this article will get you thinking about your child's feeding interactions and how you can become a more positive feeding teacher!

**References:**

