

## Raising Children with Special Needs to be Competent Eaters

Session 1: A case lesson in assessment and intervention in the child with special needs



## SATTER FEEDING DYNAMICS MODEL: fdSatter

Parents feed based on the division of responsibility  
Children remain/become eating competent

Satter In: O'Donahue W. *Pediatric and Adolescent Obesity Treatment: A Comprehensive Handbook*, 2007

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Helping children be competent eaters starts at birth and continues throughout childhood.

## ELLYN SATTER'S DIVISION OF FEEDING RESPONSIBILITY (sDOR) INFANT

- Parent: *What*
- Child: *How much*

Satter, The feeding relationship, JADA 86:352, 1986

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## ELLYN SATTER'S DIVISION OF FEEDING RESPONSIBILITY (sDOR) Toddler through adolescent

- Parent: *What, when, where of feeding*
- Child: *How much, whether of eating*

Satter, The feeding relationship, JADA 86:352, 1986

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## FOR CHILDREN TO BE COMPETENT EATERS, ADULTS MUST BE COMPETENT FEEDERS

- Choose and prepare food
- Have regular meals and snacks
- Make eating time pleasant
- Provide mastery opportunities
- Accept and support children's growth

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## BEING A COMPETENT FEEDER INCLUDES TRUSTING CHILDREN TO EAT

- Children will eat
- They know how much to eat
- They will eat a variety
- They will grow predictably
- They will mature with eating

### ELLYN SATTER'S DIVISION OF RESPONSIBILITY IN FEEDING

Children are born wanting to eat. Learning how much to eat and when to eat is part of the way that nature intended. Learning to eat with feeding practices from another throughout the growing of years. Parents provide structure, support and supervision. Children choose how much and when to eat and when they are done eating.

**The Division of Responsibility for Infants:**

- The parent is responsible for what
- The child is responsible for how much (and sometimes when)

**The Division of Responsibility for Toddlers through Adolescents:**

- The parent is responsible for what, when, where
- The child is responsible for how much and whether

**Both parents need to do with feeding include:**

- Choose and prepare the food
- Provide regular meals and snacks
- Make eating times pleasant
- Show children when they have to learn about food and suitable behavior
- See the children grow for food as hunger between meals
- Let children grow up so get better that are right for them

**Responsibility of the parent (also in teaching children to decide how much and whether to eat, if appropriate for their age) of feeding children their plate with eating:**

- Children will eat
- They will eat the amount they need
- They will eat an increasing variety of food
- They will grow predictably
- They will learn to believe what is on the table

Choosing the lines of Ellyn Satter's Division of Responsibility in Feeding is likely to cause feeding problems and should be avoided. Trying to control what or how much a child eats can have long-term consequences. When children bring the child about the family, parents, for a detailed explanation of the division of responsibility, see one of Ellyn Satter's four books: *Your Child's Weight: Helping Without Helping*, *What to Eat: Feeding Well Now and for the Future*, *Division of Feeding a Healthy Family*, or *How to Eat from Kid to Adult... And How to Eat Much*.

## fdSatter Intervention Parent leadership : : Child autonomy

When parents do their jobs with feeding,  
children will do their jobs with eating

## A CHILD WHO IS COMPETENT WITH EATING...

- Feels good about eating
- Can learn to like unfamiliar food
- Goes by feelings of hunger and fullness to know how much to eat
- Enjoys family meals

## PRESENTING COMPLAINT

Likely to be a combination

- Growth
- Feeding



## INTERVENTION STARTS WITH ASSESSMENT

- Problem is established; complicated
- Cause is unclear, likely to be multiple

Satter, E. *Your Child's Weight*, Appendix E, Assessment of Feeding/Growth Problems

## ORGANIZING LOGIC FOR ASSESSMENT

### Satter Feeding Dynamics Model

- It is normal for children to eat and grow normally
- From birth, to retain their capability with eating and growth, children need appropriate grownup support
- When a child does *not* eat and grow normally, *something* is the matter
- The organizing question is, “what is interfering with this child’s eating & growth capability?”

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## WORKING HYPOTHESIS

- Whatever the underlying issue, distorted feeding dynamics is a primary and/or adjunct cause of the problem
- Feeding intervention will be part of the resolution

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## CROSS-CUTTING THEME

- Explore factors that precipitate and may continue to exacerbate feeding distortion
- Identify factors that interfere with parents’ enacting a division of responsibility in feeding

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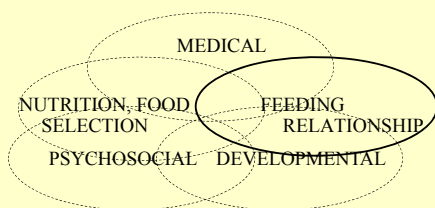
## ASSESSMENT CONTENT

- Medical & physical
- Nutrition & food selection
- Psychosocial (parents)
- Developmental (child)
- Feeding dynamics

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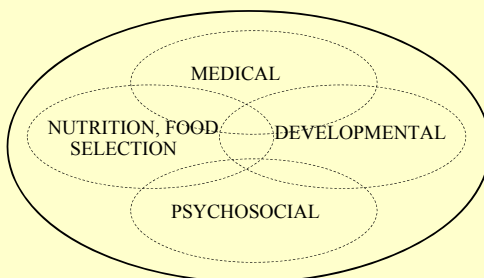
## ISSUES IN FEEDING



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## ISSUES IN FEEDING



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## MEDICAL & PHYSICAL

Clues to why child is seen as being incompetent with eating and growth

Identify whether adjunct treatment is needed

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- Review & summarize clinical record
- Re-plot growth
- Past: Was child ill? Are issues resolved?
- What were significant events?
- Present: Oral-motor problems? Illness? Other?

## NUTRITION & FOOD SELECTION

Nutrition and food selection related clues to child's seeming incompetence with food acceptance or regulation

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- Nutritional adequacy of child's food intake
- Food selection and reliability of family meals
- Fat content of diet
- Developmental appropriateness of food

## NUTRITION & FOOD SELECTION

Determine whether feeding dynamics intervention requires adjunct nutritional support

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- Assess the child's nutritional status
- Does child have nutritional reserves to support treatment?
- Provide for nutritional support

## PSYCHOSOCIAL (parents)

Identify whether adjunct therapy is necessary

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- Are parents able to institute a division of responsibility in feeding?
- Are parents able to apply the changes of treatment?
- Do parents/child require a referral to address associated/underlying issues?

## PSYCHOSOCIAL (parents)

To what extent can parents enact a *division of responsibility* in feeding?

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- Primary: Can do it
- Secondary: Can do it with help
- Tertiary: Can't do it until they resolve underlying or contextual issues

## DEVELOPMENTAL (child)

To what extent has the child accomplished psychosocial developmental tasks at every stage?

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- Homeostasis
- Attachment
- Separation-individuation
- Initiative

## FEEDING DYNAMICS

Is feeding consistent with the child's stage in development?

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- Homeostasis
- Attachment
- Separation-individuation
- Initiative

## FEEDING DYNAMICS

How does feeding distortion contribute to the child's seeming incapability with eating/growth?

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- Based on observation
- Parental report is not accurate

## IMPRESSIONS

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- Medical & physical
- Nutrition & food selection
- Psychosocial (parents)
- Developmental (child)
- Feeding dynamics

## IMPRESSIONS

### Action-oriented

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- It is about *quality* of feeding, not quantity
  - It is *not* about getting food in the child
- It is about *optimizing* the child's growth potential
  - It is *not* about correcting low weight

## IMPRESSIONS

### Action-oriented

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- It is about what is *possible* for that child
  - Developmental stage
  - Oral-motor capability
  - Stamina, attention span

## TALKING WITH PARENTS: PLANNING TREATMENT

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- Remind parents: this is a parent-centered approach
- Reconstruct the child's history: Share results of assessment
- What is causing the presenting complaint?
- Outline treatment, including recommendation (if any) for nutritional support
- Plan followup

## TRUST MODEL FOR TREATMENT

1. Parents' jobs
2. Child's jobs

## FOLLOW & SUPPORT PARENTS

- Weekly sessions (as parents can manage)
  - Optimize feeding
  - Give mastery opportunities
  - Expect child's capability to evolve
- Do problem-solving with the division of responsibility
- Detect parents' tendencies to over-encourage
- Give support for reassuring child s/he doesn't have to eat if s/he doesn't want to
- Help parents detect child's evidence of eating competence

## JOSEPH



## REFERRAL : : COMPLAINT

To: NUTRITION

From: STATE EARLY INTERVENTION PROGRAM

Child with Hypertrophic Cardiomyopathy, Tracheomalacia, low tone. Gastrostomy tube: Parents want child to eat

## ORGANIZING LOGIC FOR ASSESSMENT Satter Feeding Dynamics Model

- It is normal for children to eat and grow normally
- From birth, to retain their capability with eating and growth, children need appropriate grownup support
- When a child does *not* eat and grow normally, *something* is the matter
- The organizing question is, "what is interfering with this child's eating & growth capability?"

## Medical and Physical Assessment – 11 months 23 days

- ½ hour after birth on O<sub>2</sub> & naso-gastric feeds due to ↑ respirations & heart rate
- Feeding on demand attempted until 3 mos
  - Weight faltering
- n/g feeds resumed 3-10 mos; vomiting each feed
- 5 mos. Dx: hypertrophic cardiomyopathy
- 10 mos. Gastrostomy tube insertion
  - Weight gain

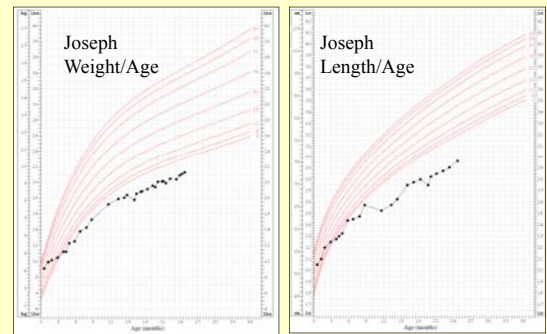
## Medical and Physical Growth – 11 months 23 days

### Growth charts from birth

- Faltering w/age pattern between 1 – 3 months
  - From 50<sup>th</sup> % to 5<sup>th</sup> %
- Similar divergence in l/age at 3 months
  - From 25<sup>th</sup> % to 5<sup>th</sup> %
- 7 – 9 months consistent pattern below 3<sup>rd</sup> %
- At evaluation (~12 months old) w/age measurement seems in line; length below pattern

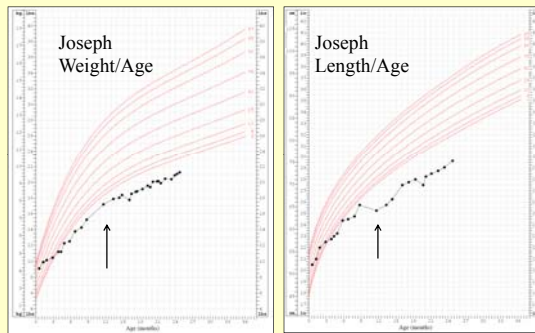
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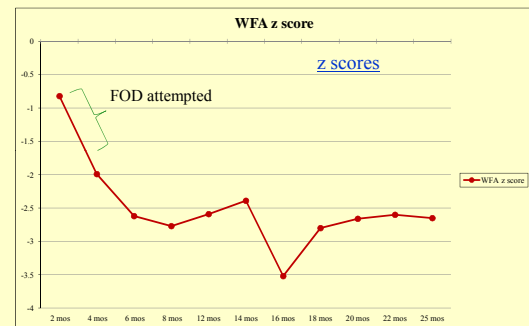
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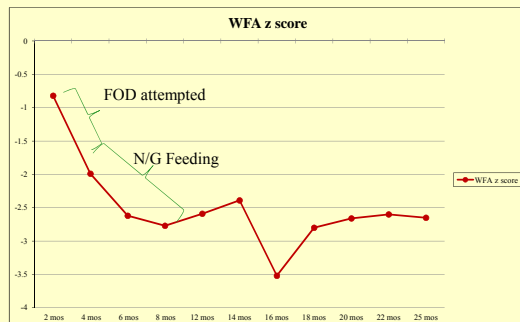
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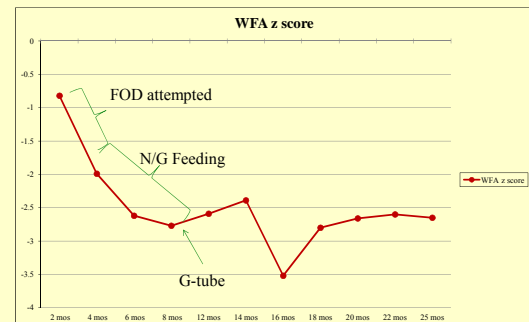
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## Assessment for Special Needs and referral for intervention

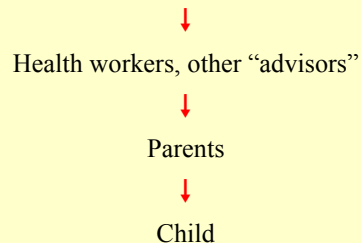
### At age 6 months

- Cognition, communication, soc/emotional within normal limits
- Physical = 2-3 months
- Adaptive = 4-6 months
- Overall low tone; concerns related to feeding and motor skills
- This therapist observation of feeding at 11 m 23d eval: spoon & nipple feedings = 5-7 month range

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## PRESSURE ON FEEDING



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## Developmental (child) Assessment – 11 months 23 days

- Homeostasis
  - Able to calm and organize
- Attachment
  - Well connected to mom
- Separation-individuation
  - Grabbing for spoon

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## Feeding dynamics Observation – 11 months 23 days

- Feeding capabilities (spoon & nipple) = 5-7 months
  - Sits alone
  - Holds head straight when sitting
  - Mom reports he opens mouth for spoon
  - Takes breaks when nipple feeding
    - 2 oz. in 5-6 mins; 20 min. break, 2 oz. 5-6 mins.

[What your baby can do...](#)

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## Nutrition & Food Selection Assessment – 11 months 23 days

- 30-32 oz. 27-cal/oz. Enfamil Lipil
- G-tube feeds 4 oz./5 x/d
- Offered nipple feedings 3 x/d
  - Routinely takes 7 oz.
- Night feeds: 40 cc/hour g-tube
- Offered baby cereal, fruits, pudding 2x/d
- Calorie needs estimated 619-928 kcals/d
- Enfamil Lipil provides 810-864 kcals/d

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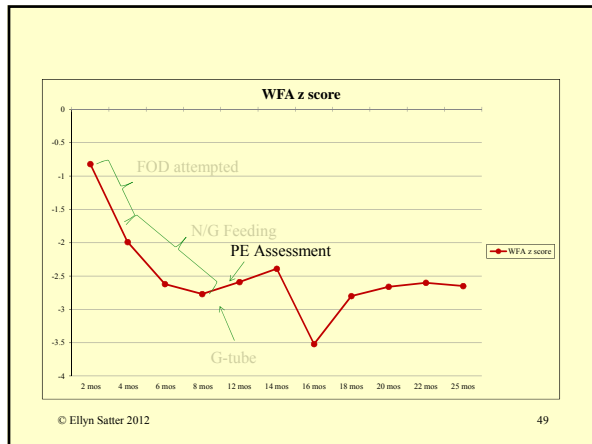
## Feeding Dynamics Observation – 11 months 23 days

- Bottle Feeding
  - Mom talks in comforting voice, rocks
  - Observes tiredness and stops when discomfort noted
  - Offers again to let him determine if he is done
- Spoon Feeding – Mom wants it to be fun
  - Mom sits directly in front; holds spoon out so he can see it
  - Puts small amount on lip and waits for him to taste it
  - He grabs for spoon often; observed to bring to mouth once
  - He sticks out tongue frequently; doesn't appear to open for spoon, but did move forward towards spoon several times

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## IMPRESSIONS

- Medical & physical
  - Shortness of breath during feeding compromised ability to eat enough
- Nutrition & food selection
  - G-tube enabled wt gain; ↑oral nipple feeding

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## IMPRESSIONS

- Psychosocial (parents)
  - Both parents present & involved; Mom primary caregiver; worries about wt gain, medical stability, oral intake
- Developmental (child)
  - Early signs of separation/individuation, grabbing spoon
- Feeding dynamics
  - Mom tuned-in; observes cues. Concerns about ↑oral feeding may result in interfering with Joseph's natural process of growing up with eating

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## Impressions

### Assessment – 11 months 23 days

- Is getting nutritional support from G-tube
- Recovering good rate of weight gain
- Willing to try food from spoon
- Spoon feeding smooth, semi-solids in line with current feeding capabilities
- Mom needs support to balance needs for weight gain and progression to solid foods

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## To what extent can parents enact a division of responsibility in feeding?

- Primary: Can do it
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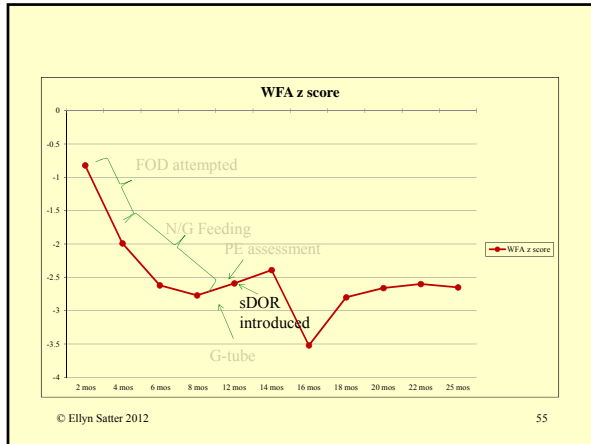
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## Recommendations

### Assessment – 11 months 23 days

- Continue to offer opportunity to eat semi-solids
  - Start with cereal and advance according to what he does
- Continue to observe and follow his cues
- Don't worry about making feeding fun
  - Time his tastes of food to your eating times. Eating with you is fun enough.
- Check weight once/month to help determine amount of g-tube feeding required to maintain steady, upward growth

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## JOSEPH'S TREATMENT PLAN

### Parents' & Child Care Providers' Jobs

- Let Joseph learn how to eat
- Gradually decrease g-tube feedings to allow Joseph to be hungry

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## JOSEPH'S TREATMENT PLAN

### Parents' & Child Care Providers' Jobs

- Establish and maintain sDOR
  - Eat with Joseph; D/C playing to get him to eat
  - Identify Joseph's eating cues
  - Offer developmentally appropriate foods within schedule
  - Identify normal child food acceptance behaviors
  - Plan good-tasting, enjoyable menus – offer Joseph what you are eating, modified so he can manage it
- Adjust g-tube feedings to growth needs & amounts taken orally

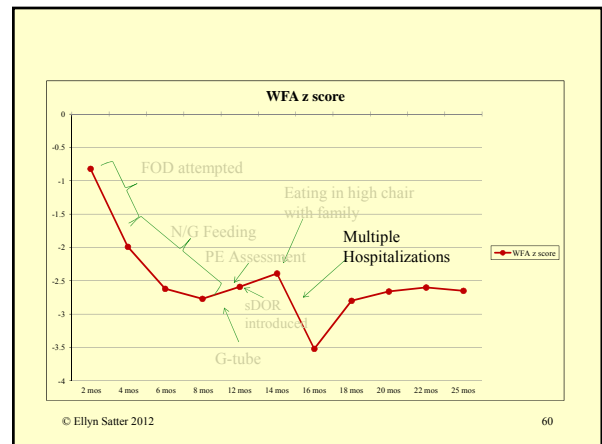
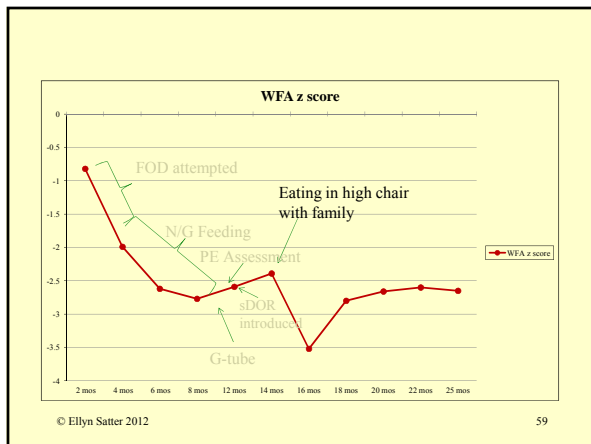
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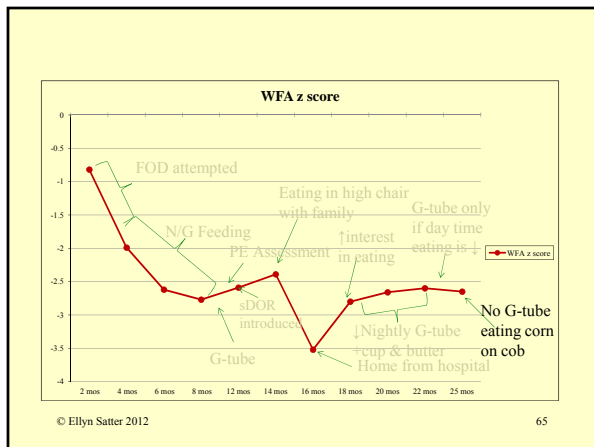
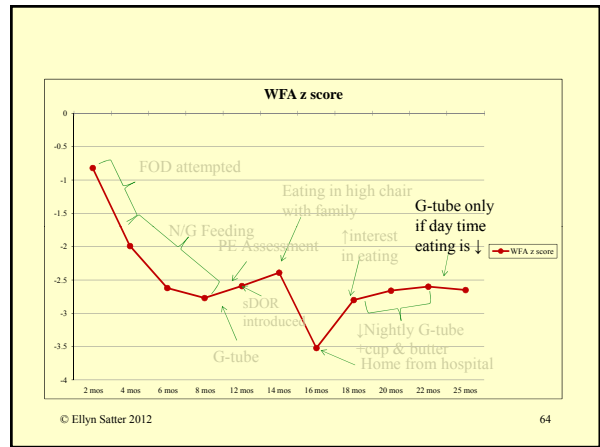
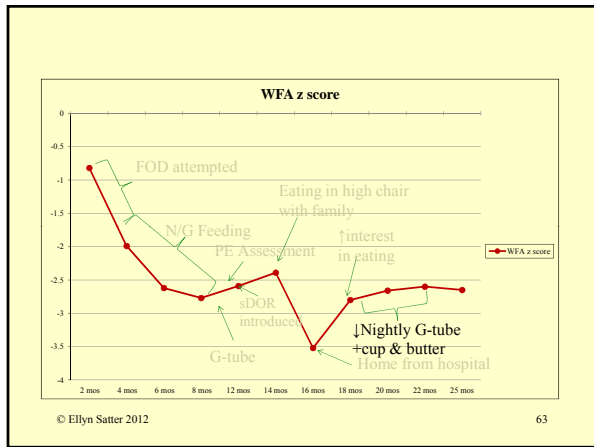
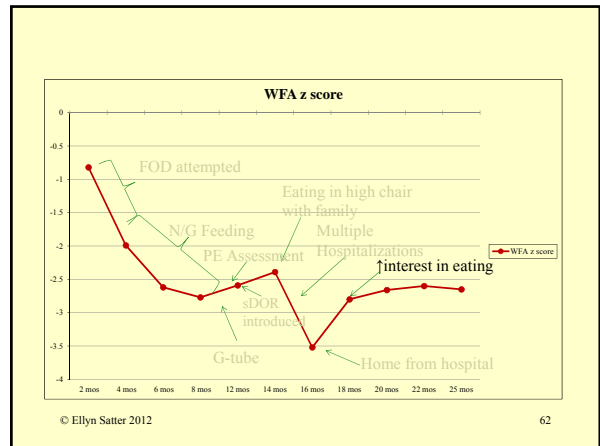
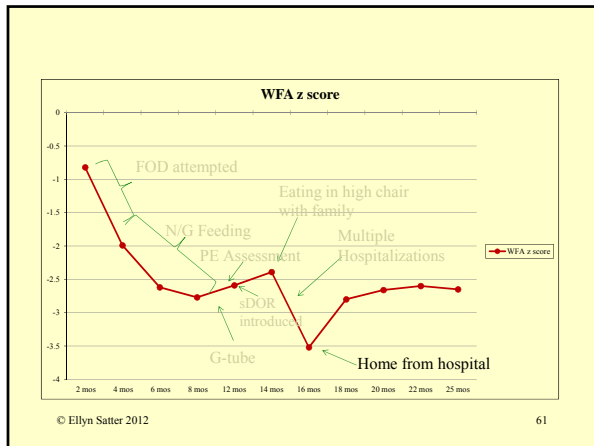
## TREATMENT PLAN

### Joseph's Jobs

- Develop positive attitudes about eating
- Get hungry and show signs of it
- Eat until satisfied – with parents' help
- Take interest in the parents' food
- Learn to eat solid foods
- Sneak up on new food and learn to like it

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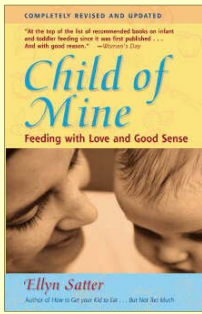


## MOVING TOWARDS TRUST

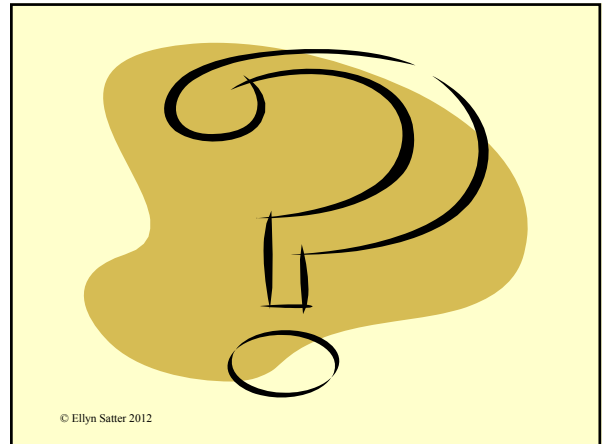



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For more information



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