Responsive Feeding Therapy: Values and Practice (Version 2)

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Acknowledgment: The responsive feeding therapy framework draws on the wisdom, knowledge and expertise of many teachers and mentors from different fields.

Introduction

This white paper offers a philosophical and clinical framework for Responsive Feeding Therapy (RFT). It is applicable to practitioners from multiple fields, working in pediatric feeding and nutrition, as well as with food avoidance across the lifespan. These professionals include speech-language pathologists, dietitians, psychologists and therapists, occupational therapists, primary care providers, and community nurses. In addition to helping clinicians understand and implement RFT, this framework provides a foundation for researchers to contribute to the empirical evidence base, and improve clinical utility.

The RFT approach and respective values build on a body of research from the field of pediatric feeding and related areas of study. This includes, but is not limited to, responsive parenting, humanistic psychology, attachment theory and interpersonal neurobiology, theories of development, self-determination theory (SDT), and trauma physiology. While separated for the sake of clarity, the values listed in the RFT framework are interrelated. For example, skill acquisition must be grounded in the context of attuned *relationships* and individual *autonomy*.

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A comprehensive history and physical exam (with further testing as indicated) must be undertaken to rule out or identify underlying anatomical, GI, metabolic, and other factors that impact eating and digestion. In cases where medical interventions are necessary (such as enteral feeding or IV hydration) the RFT values can still guide individualized treatment.

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**'In this document, 'parent' refers to care providers (family member, foster parent, nanny) involved in the feeding and care of children.*

The RFT values are: **autonomy**, **relationship**, **competence**, **intrinsic motivation**, and **holism**. The first three (autonomy, relationship, and competence) encompass the basic needs of self-determination theory and have been shown to be necessary to the facilitation of intrinsic motivation (the fourth value). The fifth value of holism (the whole child lens) is the prism through which the other values are applied.

Definition:

Responsive Feeding Therapy (RFT) is an overarching approach to feeding and eating interventions applicable to multiple disciplines and across the lifespan. RFT facilitates the (re)discovery of internal cues, curiosity, and motivation, while building skills and confidence. It is flexible, prioritizes the feeding relationship, and respects and develops autonomy

Goals:

RFT has three core goals, which both drive clinical decision making, and result from the application of the RFT values.

1) **To prioritize felt safety and nervous system regulation:** RFT centers the child's embodied experience of interoception, emotions, and nervous system regulation within the complex interconnectedness of mind and body. Felt safety refers to an unconscious sense of being secure, where the body's threat system is not activated. Felt safety is health-promoting in and of itself; a child in felt safety experiences optimal physiology in regards to digestion and gut function, the cardiovascular system, hormones, and immune function. In felt safety, appetite, capacity for relationships, and curiosity can emerge. Parents are supported to observe the child and provide co-regulation, which supports emotional and physical self-regulatory capabilities over time.
2) **To support and optimize children's relationship with food and their bodies:** Research in adults suggests that internally (versus externally) guided eating results in many positive outcomes. RFT is held to optimize self-regulation of energy intake to the best of each individual's ability (considering barriers to interoception), via a supportive and accommodating feeding environment.
3) **To provide individualized care:** When autonomy, relationship, competence, intrinsic motivation, and holism are applied in concert, the resulting values-driven treatment framework is, by its very nature, highly individualized. Such individualized care is a defining characteristic of RFT, in contrast to a manualized approach.

RFT Values:

Autonomy • Relationship • Competence • Intrinsic Motivation • Holism

Autonomy pertains to agency and respect for personal space and bodily integrity, enabling a person to be in control of their own actions.

Relationship refers to warm and attuned interpersonal connections.

Competence pertains to the individual's perceived sense of having specific skills to manage a situation, as well as their measurable skills related to eating.

Intrinsic motivation describes a desire to act that is self-driven rather than brought about by external forces.

Holism (the whole child lens) refers to a focus on the whole person in the context of their families, communities, and cultures.

AUTONOMY

What we believe:

- The child's bodily integrity ("my space, my body") must be respected.
- Strategies to 'get' children to engage with a food or therapy task (such as physical restraints, opening a child's mouth with mandibular pressure or rubber-coated spoon, holding lips or jaw closed, or non-removal of the spoon) undermine autonomy.
- "Gentle," non-physical encouragement can also undermine autonomy (including praise, rewards, bribes, even playful games with the goal of getting children to eat).
- The child's agency ("I decide") must be prioritized.
- Crying, gagging, or vomiting are not 'behaviors to extinguish,' they are responses to past or current negative experiences with food or eating (including, but not limited to, developmental and/or medical challenges, and compromised autonomy).
- Therapeutic goals are guided by the child's current presentation, skills, and readiness.
- Autonomy and felt safety are not to be compromised for treatment goals such as increasing volume and/or variety (see Competence).

What we do:

- Uphold a child's right to say "no."
- Attend and respond to verbal and non-verbal communication.

- Neither recommend nor implement negative consequences (such as taking away screen time or withdrawing affection) if a child decides not to eat, interact with a food, or engage in a therapeutic task.
- Provide developmentally appropriate support designed to cultivate and foster autonomy.
- Consider each child's temperament, abilities, and sensory profile so they can discover ways to interact with food that are comfortable and positive.
- Help parents remove barriers to - and provide autonomy-supportive opportunities for - children engaging with food.

RELATIONSHIP

What we believe:

- Parents are not to blame for feeding challenges.
- Parents are doing the best they can.
- The feeding relationship between parent and child is central to the child's long-term well-being.
- High levels of (parental and child) anxiety, and conflict around feeding impact the parent-child relationship beyond mealtimes.
- A parent's ability to regulate their own emotions and experience felt safety supports co-regulation, enhancing the child's experience of felt safety.
- Positive and sustainable changes are more likely to take place when a child feels a sense of well-being and emotional security.
- Healing from trauma happens within trusting relationships.
- As with autonomy, healthy attachment and trusting relationships should not be compromised for short-term feeding goals (such as bites or calories).
- Trusting relationships between child and practitioner, and parent and practitioner, facilitate healing.

What we do:

- Listen to, acknowledge, and address parental worries about weight, growth, intake and nutrition as well as psychosocial pressures, such as judgment from peers.
- Help parents identify and replace maladaptive feeding practices with responsive practices including:
    - Modeling positive eating experiences
    - Establishing an appropriate structure and environment for eating
    - Encouraging communal eating, and addressing obstacles to family meals
    - Responding to children with emotional warmth
    - Where appropriate, ensuring children are exposed to a variety of foods - even if they are not ready to eat them yet - alongside accepted foods.

- Emphasize the importance of positive, attuned relationships with parents, caregivers, and clinicians.
- Hold space for parents to process difficult feelings experienced in the feeding relationship.
- Offer resources and psychoeducation to build resilience and anxiety management skills in both parents and children.
- Work with childcare providers, schools and the wider support network to implement responsive feeding principles consistently in all of the child's natural environments.
- Support relationship-building and responsive parenting.

COMPETENCE

What we believe:

- A positive relationship with food and the skills to eat are attainable goals for most children, even those with severe challenges.
- The acquisition and development of skills, including feeding and other motor skills, is a process of discovery optimally experienced through meaningful activities in a natural context.
- Children gain skills in a safe and meaningful environment, to the best of their abilities (including those with developmental and/or motor disabilities).
- Even children who have never eaten by mouth may not need skill interventions (including nonnutritive chewing or oral-motor exercise).
- When necessary, any interventions with the child directly should consider the child's capabilities and development.
- Progress is not simply measured in bites taken or number of accepted foods.
- Early progress such as comfort, decreased anxiety, and curiosity builds a foundation that opens the door to increased variety and development of eating skills.
- Parents' competence as feeding partners increases as they see early progress and success.
- Long-term healing may take place over an extended period, at a pace that is comfortable to the child.
- The nature of progress differs from one child to the next.
- A focus on skill development beyond the child's pace and stage can result in dysregulation and hinder progress.

What we do:

- Help the child build skills and confidence at their own pace.
- Work with children at their clinically-relevant developmental stage, regardless of age.

- Facilitate progression within the zone of proximal development for that child, ensuring that therapeutic expectations are both sufficiently challenging and attainable, and allow for adaptations based upon the child's responses.
- Support natural and meaningful opportunities (such as shared meals or food preparation) to have positive experiences with food and allow the child to gain skills at their level of comfort and interest.
- Introduce skill-building interventions with caution after optimizing the feeding environment, considering the impact on autonomy, and level of comfort with food.
- Maintain mealtimes as 'safe zones' where any skill development strategies or clinical interventions are guided by the child's comfort and enjoyment.
- Discuss therapy goals with parents and the sequence of progress, for example, eating out at a restaurant may require many smaller, interim goals.
- Draw parents' attention to early, foundational progress in emotional, social, self-regulatory and sensory-motor realms.

INTRINSIC MOTIVATION

What we believe:

- Children do well with eating when they can.
- Humans eat for many reasons including fueling their bodies, comfort, pleasure, novelty, and enjoying culture and community.
- Positive mealtimes, however limited the diet, are central to improving the child's relationship with food.
- Almost all children have an innate capacity to regulate energy intake, which can continue into adulthood if nurtured (including neurodivergent individuals, and many children with avoidant/restrictive food intake disorder (ARFID), medically complex situations, and children fed by a feeding tube).
- Medications, medical conditions, anxiety, and sensory differences can affect interoception and self-regulation, and benefit from responsive support.
- Eating may not be a pleasurable experience for everyone, but mealtimes can become neutral or positive, and offer nurturing social interactions.
- A child's anxiety hinders intrinsic motivation, internal cues of hunger, a sense of relatedness, and feeling safe.
- Parental anxiety, misperceptions, and misinformation often contribute to maladaptive feeding, which thwarts the child's ability to recognize and respond to intrinsic drives.
- Strategies that rely on external motivation, such as rewards, persuasion, or inducing fear of negative health consequences, may 'work' in the short term, but can override the child's ability to listen to their body, limiting long-term, sustainable change.
- While sensory, oral-motor, or graded exposures may be helpful in some cases, goals and progress should be guided by the child and not externally imposed by adults.

- Long-term, sustainable change is underpinned by intrinsic motivation and internal drives including hunger, the seeking of pleasure and new experiences, curiosity, and a striving for competence.
- Goal-driven and adult-guided food play or activities can increase anxiety in children, burden caregivers, and increase an unhelpful focus on food.

What we do:

- Nurture appetite through flexibly structured eating, supporting the experiencing of hunger and satiety.
- Support opportunities to engage with food in natural and meaningful contexts (such as baking dog treats or picking apples).
- Help parents feel comfortable allowing their child's eating to be intrinsically motivated - as opposed to externally driven - by addressing parental worries (e.g., about nutrition, growth, or appetite), and providing reassurance and anticipatory guidance.
- Support parents to allow children sufficient time to tune in to internal signals of appetite, and hunger (which can take several months following the establishment of responsive feeding practice).
- Address mealtime stress and conflicts and create positive eating experiences so parents and children can come to the table as calm and relaxed as possible.
- Determine what is getting in the way of the child's eating and positive relationship with food, rather than "how do I get the child to eat?"
- Provide information regarding development and developmentally appropriate skills, strategies, and expectations, such as serving sizes, schedule, or length of mealtimes.
- Support children with interoceptive differences or challenges (including medications) with developmentally appropriate, individualized, gentle external support, such as serving regular meals and snacks or use of prompts such as apps or visual schedules (these may be transitional or needed long-term).

HOLISM

What we believe:

- Every child is an individual with a unique history and differing needs.
- It is problematic to view feeding differences and challenges as located solely in the child.
- Child feeding difficulties need a 'big picture' approach, encompassing child factors, parent factors, the family system, socio-economic, and cultural influences - both past and present.
- Childhood adversity (including ACES), complex trauma (CPTSD), pre-natal exposures (such as FASD) and food insecurity (among other factors) can contribute to feeding challenges.

- Humans come in a range of sizes and weights, impacted by many factors.
- Foods have many qualities in addition to nutrients including texture, compatibility with the child's skills and sensory needs, and caloric value; all of the qualities of foods should be taken into account as opposed to absolute notions of 'healthy' or 'unhealthy.'
- While neurodivergent (ND) clients can have feeding differences and challenges, the goal is not to turn them into "typical" eaters, but to support them to eat in ways that enhance their wellbeing.
- A child's optimal nutrition and growth can look different case by case and are outcomes of responsive feeding relationships and a positive relationship with food.
- Cultural and religious practices, foods, and values (such as hand feeding or eating on the floor) should be explored and incorporated in treatment.

What we do:

- Seek first to understand why a child is struggling or refusing to eat.
- Consider, rule out, treat, and refer as appropriate for medical, sensory-motor, social and emotional underlying challenges.
- Consider trauma, whether environmental, medical, developmental, or due to prior experience of feeding and/or therapies.
- Avoid (re)traumatizing children in the therapeutic setting (focus on felt safety).
- Allow each child's intrinsic motivation and goals (including hunger, curiosity, and desire for social connection) to guide therapeutic interventions that support child-directed eating.
- View and talk about foods in neutral terms.
- Avoid over focusing on specific foods such as vegetables, and help families make food selections which consider all of the factors that can make a food a good choice for an individual child.
- Consider societal inequities which may impact interventions, including screening for food insecurity and adjusting treatment accordingly and referring to resources where applicable.
- Make space for flexibility in goal setting and treatment planning.
- Seek to understand individuals' social, historical and cultural contexts, and practice with cultural humility.
- Enquire (and adjust) around best communication methods with caregivers (such as with hearing impairment or needs associated with neurodivergence).
- Support parents of neurodivergent children, or children with sensitized nervous systems, to optimize the feeding environment to reduce anxiety and pressure.

RFT across the lifespan

While this white paper has a practical focus on children, RFT is relevant for those working with adolescents and adults because:

1) The majority of adolescents and adults with food avoidance, including ARFID (particularly low appetite and "sensory" subtypes), experienced differences and symptom onset in early childhood. Therefore, an understanding of the early feeding environment, and factors that contributed to avoidant eating, informs treatment across the lifespan.
2) While the RFT values and therapeutic principles are heavily informed by best practices in pediatric feeding, these fundamental values can also inform treatment for avoidant eating in adolescents and adults.

RFT is not designed for use with eating disorders characterized by concerns about body size and weight such as anorexia nervosa, particularly where the individual is more medically and nutritionally compromised, and with a more acute weight loss trajectory. However, elements may be applicable.

Work on the application of RFT in the context of adolescents and adults is ongoing. Considerations unique to these populations:

When working with adolescents, clinicians must understand and consider development and issues specific to adolescence, such as growth during puberty, and increased social pressures. Additionally, adolescents and parents are navigating the balance between family involvement and independence, often reflected in the feeding relationship. RFT addresses the parent-child feeding relationship, and the adolescent's growing independence.

RFT in adulthood prioritizes a trusting therapeutic relationship and emphasizes helping the client understand and accept their current relationship with food as part of the process of change. Client autonomy is central, and treatment plans are devised collaboratively. Each case is unique and clinicians take time to understand the antecedents and contributing factors around eating challenges (such as childhood experiences, oppression of marginalized identities, sensory profiles, or aversive experiences) coupled with the client's current family system and lifestyle.

Selected Relevant Publications

- Birch, L. L., & Deysher, M. (1985). Conditioned and unconditioned caloric compensation: evidence for self-regulation of food intake in young children. Learning and motivation, 16(3), 341-355.
- Black, M. M., & Aboud, F. E. (2011). Responsive feeding is embedded in a theoretical framework of responsive parenting. The Journal of nutrition, 141(3), 490-494.
- Cormack, J., Rowell, K., Postavaru, G.I. (2020). Self-Determination Theory as a Theoretical Framework for Responsive Approach to Child Feeding. Journal of Nutrition Education and Behavior, 52(6), 646- 651. https://doi.org/10.1016/j.jneb.2020.02.005
- Daniels, L. A. (2019). Feeding practices and parenting: A pathway to child health and family happiness. Annals of Nutrition and Metabolism, 74(2), 29-42. https://doi.org/10.1159/000499145
- Davies, W., Satter, E., Berlin, K. S., Sato, A. F., Silverman, A. H., Fischer, E. A., ... & Rudolph, C. D. (2006). Reconceptualizing feeding and feeding disorders in interpersonal context: the case for a relational disorder. Journal of Family Psychology, 20(3), 409.
- Galloway, A. T., Fiorito, L. M., Francis, L. A., & Birch, L. L. (2006). 'Finish your soup': counterproductive effects of pressuring children to eat on intake and affect. Appetite, 46(3), 318-323.
- Jaffe, A. C. (2011). Failure to thrive: current clinical concepts. Pediatr Rev, 32(3), 100-107. https://doi.org/10.1542/pir.32-3-100
- Kerzner, B., Milano, K., MacLean, W. C., Berall, G., Stuart, S., & Chatoor, I. (2015). A practical approach to classifying and managing feeding difficulties. Pediatrics, 135(2), 344- 353. https://doi.org/10.1542/peds.2014-1630
- Leung, A. K., Marchand, V., Sauve, R. S., Canadian Paediatric Society, & Nutrition and Gastroenterology Committee. (2012). The 'picky eater': The toddler or preschooler who does not eat. Paediatrics & child health, 17(8), 455-457. https://doi.org/10.1093/pch/17.8.455 Satter, E. (1986). The feeding relationship. Journal of the American Dietetic Association, 86(3), 352-356.
- Segal, I., Tirosh, A., Sinai, T., Alony, S., Levi, A., Korenfeld, L., Zangen, T. Mizrachi, A., Boaz, M. & Levine, A. (2014). Role reversal method for treatment of food refusal associated with infantile feeding disorders. Journal of pediatric gastroenterology and nutrition, 58(6), 739- 742. https://doi.org/10.1097/MPG.0000000000000309
- Slaughter, C. W., & Bryant, A. H. (2004). Hungry for love: the feeding relationship in the psychological development of young children. The Permanente Journal, 8(1), 23.
- Walton, K., Kuczynski, L., Haycraft, E., Breen, A., & Haines, J. (2017). Time to re-think picky eating?: a relational approach to understanding picky eating. International Journal of Behavioral Nutrition and Physical Activity, 14(1), 62. https://doi.org/10.1186/s12966-017-0520-0
- Zickgraf, H et al (2019). Characteristics of Outpatients Diagnosed With the selective/neophobic Presentation of avoidant/restrictive Food Intake Disorder. Int J Eat Disord Apr;52(4):367-377.