

Foreword

In the second edition of *Pre-Feeding Skills*, Suzanne Evans Morris and Marsha Dunn Klein will be telling you over and over in many ways that feeding is far more than getting food into a child. Feeding is a relationship; treating a child's eating behavior and treating the interactions between parent and child around feeding is deeply based on trust. Over the years as I have delivered that message to health professionals, I have found it is not always a welcome one. It is not easy for professionals trained in nutrition, medicine, or another physically oriented field to discover that their endeavor is embedded in social and emotional issues and family dynamics. In this book, you may be asked for the first time to grapple with the impact of a child's social, emotional, and physical milieu as part of helping him or her with eating.

Like Dorothy getting carried up in the tornado, you may have mixed feelings that this topic will so clearly take you out of Kansas! I felt pretty twisted around myself 20 years ago as a nutritionist raising my own children, counseling others on food selection and feeding, and finally writing on the topic. It all seemed so clear before it dawned on me that there is a good bit more to feeding than understanding nutrition. I grappled with those issues, which I came to call the feeding relationship, in my books, *Child of Mine: Feeding with Love and Good Sense*, *How to Get Your Kid to Eat...But Not Too Much*, and *Secrets of Feeding a Healthy Family*. I continue to grapple with them in articles I have written since that time, many of which are referenced throughout *Pre-Feeding Skills*. Here is a word of encouragement: In time, thinking in the broader context of relationships will become comfortable and automatic to you, too.

Feeding demands a division of responsibility. The parent does the what, when, and where of feeding. The child does the how much and whether of eating. The parent does the feeding; the child does the eating. The division of responsibility assumes that children have considerable capability with eating, but manifesting those capabilities depends on parents effectively executing feeding tasks. Parents are responsible for choosing and preparing food, maintaining the structure of meals and snacks, making eating times pleasant, and providing mastery expectations. Given parents' successful execution of their tasks, children will increasingly gain capability with eating behavior and food acceptance, retain the ability to regulate food intake and grow in a constitutionally appropriate way, and maintain positive eating attitudes and behaviors. The feeding relationship begins and ends with trust: trust that the child wants to eat, knows how much to eat, and wants to grow up with eating. If a child doesn't seem to want to eat, then something is the matter: That child is being forced in some way or insufficiently supported in his or her struggles to grow up.

For children with neuromuscular or cognitive limitations, maintaining that trust and observing a division of responsibility in feeding takes on a special meaning. Let me give you examples of how each of your authors has interpreted that meaning. Suzanne Evans Morris has consistently demonstrated that a child who can't eat enough to maintain nutritional welfare can be trusted in the feeding process. She emphasizes the richness and rewards of the feeding relationship and insists that the child with even severe neuromuscular and or cognitive limitations is entitled to master and enjoy eating to the limits of his or her ability. Tube feedings can be used as an adjunct to feeding but may not replace the feeding for many children. Morris emphasizes that the child does not have to be fully supported nutritionally through his own efforts for feeding to enhance his joy, sense of himself, and the parent-child relationship.

Feeding is about respect and about letting the child be responsible for acting on her own behalf. How can one expect such mastery from a child who is afraid to eat or even to have anything come near her mouth? Many clinicians who do oral desensitization with children resort to control in its various forms: trickery, bribery, cheerleading. Marsha Dunn Klein has the trusting answer to the dilemma. Get the child's permission, she insists. Don't put anything in the child's mouth unless she indicates she is ready to have you do it. Given enough time and a positive and trusting relationship between a child and the feeding therapist (and that child's parents), the child will grapple with his or her own anxiety and determination to grow and eventually do what is feared. Children want to learn and master, but they depend on adults to provide mastery opportunities and to mete out the challenges so they are not overwhelmed. Klein is a perfect wizard at keeping children in control by breaking pre-feeding skills into ever smaller steps to give children manageable opportunities to learn.

In beginning to work with relationships, however, it is important to recognize the limits of your involvement. You are not doing psychotherapy. There is a dividing line between feeding therapy and psychotherapy. I am a psychotherapist in addition to being a nutritionist, and I have been able to define that line. You may certainly work with feelings and, in fact, you must recognize them, encourage their expression, and accept them. People learn better when they are emotionally engaged. However, you are crossing the line into psychotherapy when, in order to achieve feeding goals, you try to change the parent's or the child's feelings or life circumstances. Your task is to satisfy yourself, through the help of *Pre-Feeding Skills* and your own experience, that your behavioral and educational interventions are realistic. If a parent can't apply scrupulously realistic interventions, you can be clear that processes going on within the parents, the child, or in their lives are simply too overwhelming to allow them to change. Before feeding therapy can continue, outside help is needed from a physician, nutritionist, mental health professional, or social caseworker to bring the child and parent to the point where they can be successful with a feeding intervention. In these days of the shrinking health care dollar, you may be asked to do it all. Don't. There is a great deal you can do, but your doing requires reasonably well-functioning parents who are not overwhelmed by unresolved medical or nutritional issues.

Helping a child to be all he or she can be with eating is inspiring and rewarding work that will draw on all of your skills. Through it all, your best guide is your trust in the child and your respect in that child's desire to be all he or she can be. Let me share a story from the toddler chapter in the current edition of *Child of Mine: Feeding with Love and Good Sense*. Thirteen-month-old Tobin had been born with cognitive and neuromuscular limitations and skeletal malformations. He had done just fine with nipple feeding, but at age 4 months when his mother tried to introduce solid foods, it went so poorly that she backed off and didn't offer them for a considerable time. An occupational therapist was working with Tobin to desensitize his mouth, and a physical therapist was helping him with muscle control. He was doing fine. It didn't scare him or turn him off to be offered soft table food. He could mouth and swallow, but he just wasn't interested. His mom complained that it was an all-day job to feed him and during feeding he gagged a lot even on semi-solid food. He seemed to enjoy holding other food, but it was hard for him to get it in his mouth, and when he did, he gagged.

Rather than continuing to work with him on pre-feeding skills, the decision was made to include Tobin in family meals. His parents were game, so they brought him to the table, propped him up in his high chair, and put small pieces of whatever they were having in front of him. The parents were warned not to pressure him in any way to eat and reminded that their cheering and clapping amounted to pressure. Imagine everyone's surprise when Tobin's face brightened up, he focused his attention on the food, and he began to struggle to pick it up. At first he just chased food around the tray, but

his mother helped by finding the distance for his arm reach that enabled him to most easily grasp the food. It worked like a charm. Tobin quickly developed the increased muscle control he needed to feed himself, chew, and swallow. Gagging stopped being a problem once he was sitting upright in the chair and feeding himself. You can imagine Tobin's breathless audience and how his parents had to positively sit on their hands and zip their lips to keep from interfering. Awed and astonished and through their tears of joy, the parents could only admire their determined son as he struggled to do it himself.

The feeding therapist made her recommendations based on her understanding of child development and social needs: Tobin was at an age where he was striving for autonomy at the same time as he wanted to be a part of his family. Beyond that, this small miracle could only have happened in the midst of relationship. Tobin's occupational and physical therapist had worked with him so carefully and well that Tobin had retained his positive feelings about eating. The family trusted the feeding therapist, and Tobin trusted both her and the parents. Tobin wanted to be at the family table, he wanted to eat, and he wanted to do it himself. And he did.

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