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Parent's/Caregiver's Relationship and the Impact on Nutrition

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Abstract: *The social–emotional interactions between parent and child are critical to an adaptive eating pattern. A complete assessment of feeding and nutrition requires inquiry into the caregiver/parent–child relationship during eating. This article details the 6 areas of social functioning derived from the six functional emotional milestones of the DIR/Floortime (DIR = Developmental, Individual Difference, Relationship) approach. When inquiry into these six areas is included in a comprehensive feeding assessment, there are direct implications for treatment planning and ultimately treatment effectiveness. These six areas are (1) the mood or emotional tone in the mealtime interaction; (2) pleasure in the introduction and exploration of new foods together with parents; (3) the parent's ability to attune to child's communicative attempts; (4) the parent's ability to support the child's drive to independence; (5) the parent's ability to engage in play and conversation about feelings, imagination, and creative ideas; and (6) the parents' ability to provide logical and accurate meanings to the child's behavior and questions. By gaining a thorough assessment of the child's interactions with their caregiver/parent, a clinician will be able to formulate intervention strategies that take advantage of the strengths in the relationship, and identify areas where they can support further developmental growth.*

Keywords: developmental delays; growth and development; autism and diet; early life span nutrition; developmental disabilities; special health care needs

"Eating is a highly social experience, and the social–emotional interactions between parent and child are critical to an adaptive eating pattern."

Eating is a highly social experience, and the social–emotional interactions between parent and child are critical to an adaptive eating pattern. Typically, feeding assessments focus on the tangible aspects of feeding: oral-motor ability, growth history, oral/gastrointestinal function, sensory processing, food choice, behavior, development, and diagnoses.[1-9] Caregiver stress, mental illness, or parenting beliefs are also frequently considered.[10-15] Although this information is necessary in creating successful intervention, a complete assessment of feeding and nutrition requires additional inquiry into the caregiver/parent–child relationship during eating. It is simpler to consider a child's behavior or even a parent's behavior in isolation, but a comprehensive assessment requires investigation of the dynamic interaction pattern between parent and child.[5,7,16]

For children with behavioral and developmental challenges, and those with medical conditions, the parent–child relationship around food and eating is changed.[3-5] High levels of parental stress often occur when a child has difficulty with eating.[12,17,18] Often parents are able to accommodate to their child's special needs; however, professional support and advice may be needed for success.[18]

This article presents 6 basic elements of a qualitative assessment of parent–child interaction around feeding, based on the DIR (Developmental, Individual Difference, Relationship)/Floortime

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approach.[19,20] This framework is based on 16 years of clinical experience from the Interdisciplinary Feeding Team and is offered as a component of a thorough feeding assessment, to gain a comprehensive understanding of the feeding challenges, including the dynamic patterns of parent–child interaction. Information about parent–child interaction is derived through observation, and open-ended inquiry into the history of interaction, and parents' perceptions, thoughts, and feelings about their feeding experience with their child. When inquiry into these 6 areas is included in a comprehensive feeding assessment, in addition to traditional assessment of sensory, motor, and medical feeding barriers, there are direct implications for treatment planning and ultimately treatment effectiveness.[20-24]

1. *Safety*: A child must feel a sense of calm, security, and safety in order to maximize his or her ability to read and respond to internal cues of hunger and satiety. This sense of safety for a child is created by the security provided by loving shared attention with the parent. If the parent is disappointed and angry, fearful and anxious about their child's health and intake, or depressed and unavailable, the child may also become depressed and withdrawn, or anxious and irritable. The child may experience depressed appetite, or shift into sympathetic "fight or flight" mode, which also overrides the drive to eat. Sometimes this behavior leads to a vicious cycle of further distress for the parent, and escalating maladaptive behavior.[23] An assessment must determine the mood or emotional tone in the mealtime interaction. A primary focus of intervention may be to help the parent to calm himself or herself, through an interactive process with the therapist, building on shared understanding, goals, and a knowledgeable and hopeful treatment plan. Triggers to the parents' anxiety, such as seeing their child gag or vomit, must be handled in a way that does not increase the stress for the child but provides for their safety.
2. *Warmth and trust*: Going beyond the basic reflexive need to eat, a child also relies on curiosity and trust to explore new foods, and to approach foods that require new motor skills. Parents typically enjoy this shared experience, but if the parent feels anxious, pressured, or genuinely does not like the food themselves, this process can be disrupted.[13,14] Sometimes a child struggles with food mismanagement, such as slight cough or gag. This occurs even in typically developing children. A parent can support a child's sense of safety by responding calmly while ensuring their child's safety. An essential ingredient to successful feeding intervention is that the perspectives and needs of the parents or primary care providers are considered as well as that of the child, and that it is an enjoyable experience for all. An assessment must determine if there is true pleasure in the introduction and exploration of new foods together with parents. Intervention often involves helping parents to rediscover ways to enjoy food exploration with their child. If they have had negative experiences with offering foods, which are unpleasant for the child, and disappointing rejections for the caregiver, both parents and child may approach food exploration with dread. With the help of a relaxed and playful therapist, parent and child learn that this experience, when approached with respect for the child's tolerance level, can build a shared experience of pleasure and trust. This is required to achieve meaningful feeding goals.
3. *Two-way communication*: At a very early age, children begin to express through gestures and vocalizations their desire for another bite, a preference for a particular food, or signals that they are hungry or full. Children with developmental challenges may be unable to indicate preference or distress in a manner that the parent can understand, and parents may be too preoccupied to read their signals accurately. It is critical to the parent–child relationship that a parent recognizes their child's cues and responds in a way that is respectful and supportive.[14] An assessment must determine if the parent is able to attune to child's communicative attempts, and respond in a contingent and helpful manner, encouraging the child's choices and initiative. If a parent is unaware of their child's intent, or anxiously seeking to control the interaction, a therapist can support the parent to find a pace of interaction that allows both parent and child to engage in a reciprocal interaction. When this is accomplished, both parent and child are building important skills for their growing relationship, and for a harmonious interaction around the increasingly complex interactions around meals.
4. *Problem solving*: At around 12 to 18 months of age, children typically are making large strides toward independence. They want to feed themselves and the transition from being fed to self-feeding requires patient negotiation with the parent. A successful transition to self-feeding contributes to a child's self-confidence and a growing ability to monitor and respond to his or her own internal cues. If a parent overrides the child's cues, or simply misses or ignores their cues, the child will begin to resist and refuse the foods offered.[14] An assessment during this period will inquire about the child's drive to independence, and the parent's ability to support this transition, and to patiently co-regulate the high emotions that occur at this time. Frequently in practice, a parent will miss their child's desire for independence. Perhaps because the child has had some special health or developmental issues, the parent is especially involved in caring for their child, and perhaps views their child as less capable. Parents are always

concerned that their child eats well, and want to do everything possible to help their child. This view, both conscious and unconscious, may hinder them from recognizing and enjoying their child's burgeoning interest in independence. Often, a clinician can help the parents to consider the happy possibility that their child is ready to do more on their own. A shift in focus can sometimes lead to surprising success. Of course, independence does not occur smoothly, and children at this stage can display amazingly intense emotions. Parents may need support to reflect on their own feelings and responses, when they have complex past history, thoughts and expectations around feeding.

5. *Talking about feelings*: When children develop the ability to use language, they quickly learn to use words to express their feelings, opinions, and ideas, and simultaneously use pretend play to act out feeding to their dolls and animals, or other aspects of nurturance, assertiveness, aggression, or fear. They enjoy the world of pretend and emulate and admire fantasy characters and their actions. Mealtimes are replete with evidence of this new ability and interest: Note all the cups, spoons, and plates with favorite characters, food packaging, and foods that are decorated to look like faces or animals. Parents may indulge the child and encourage this imaginative world, or may be too anxious to allow this to enter the mealtime experience. When a child is having challenges around eating, it is useful to understand their capacity to use this type of symbolic thinking. This ability can provide an important resource to support them to feel safe, to be brave and strong, and to manage the strong emotions that can be evoked by difficulties in eating.[24,25] A thorough assessment will determine if the parents engage in conversation about feelings, imagination, and creative ideas and support the use of characters or pretend during meals. During feeding intervention, a clinician can model with and for the parent, how to bring symbolic ideas into food exploration and eating. When this avenue of expression is opened, it is possible to discover strong feelings and ideas a child might have as they share their ideas about the eating experience. This ability provides the child with more of their own strategies to cope with difficult challenges. They can emulate their favorite, brave and powerful superheroes, or bring feelings of nurturance into their shared social experience around food. They begin to be interested in planning around meals and food categories.
6. *Understanding of food and eating*: Gradually, a child develops greater capacities for differentiating fantasy from reality, and begins to use logical reasoning to understand and question. At this stage, a child may become more interested in where the food goes, why it is important to eat, and why certain food choices are better than others. They may also relate their behaviors to how others feel about them: proud, ashamed, embarrassed, or worried. They may have their own goals for eating or unfounded fears.[26] It is important to help children clarify facts when they may be confused or frightened, and to provide reasons which meet their developmental ability to understand multiple perspectives and complex feelings. An assessment of feeding skills should probe a child's capacity to use logical reasoning, as well as the parents' ability to provide logical and accurate meanings to the child's questions and the eating goals. Often, parents are unaware of the confusion or misunderstandings a child might hold. They may even contribute to this by their own statements. In addition to supporting communication of accurate information, a clinician can also support the feeding goals by engaging the child in the process of setting goals and monitoring progress, and ensuring that the parent enlists all the family members to be respectful and supportive of the child's thoughts and feelings about their eating challenges.

Eating is a complex process that is not "taught" but develops through the interplay of instinct, hunger, and social modeling.[27] As impairments in sensory processing or motor coordination/planning are addressed and medical obstacles (anatomical or physiological) are resolved, the social barriers to eating require equal attention. Gaining more information about the strengths or constrictions in a parent–child interaction can help guide the therapist's interaction with the parent, not separately, but as part of feeding which is by its nature an interactive process. Including a thorough assessment of the child's interactions with their caregiver/parent, a clinician will be able to formulate intervention strategies that take advantage of the strengths in the relationship, and identify areas where they can support further developmental growth.[26] By using the DIR framework to focus on specific target areas within the interaction, the therapist is not judging parents or parenting, but rather considering the collaboration within the cultural context of the family. It is particularly important to assess all 6 levels of functioning. In this way, a clinician can be confident that their priorities and strategies are commensurate with the functioning of the parent–child interaction.

The interactional skills will change over the course of treatment, and require continuous reassessment. In addition to ongoing qualitative assessment through observation, quantitative assessment occurs through attainment of measurable feeding goals and assessments, including consistent weight or linear growth, inclusion of targeted foods, minutes of use of mealtime distractions, or increase/decrease of parental verbal or physical prompting to eat. Validated assessment tools also can be used to measure changes in both feeding behavior and parent–child interaction.[7,9,10,22] By including social–emotional functioning in the overall treatment planning, the child

will not only learn specific feeding skills but will also have gained the social skills needed for long-term enjoyment of the eating and mealtime interaction.

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