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In This Issue

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Articles about successful programs, research interventions, evaluations and treatment strategies, meeting announcements and information about educational programs are welcome and should be sent to the editor by the next deadline.

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Feeding Difficulties: What to look for and how to help

By Cathleen C. Piazza, Ph.D. and Kristi Murphy, MS

Most parents would agree that successful feeding of their child is a satisfying experience that affirms their competence as a caregiver. And in fact, most parents take for granted that their child will consume sufficient calories to gain weight and grow. Therefore, the emergence of feeding problems is a cause for significant parental concern and anxiety. Parents of children with feeding problems often express feelings of inadequacy and rejection, and they develop both realistic and catastrophic concerns of the risk that a feeding problem poses to their child (Lindberg, Bohlin, & Hagekull, 1991).

Feeding problems are quite common in children. In fact, approximately 25% to 35% of typically developing children and approximately 33% to 80% of children with developmental delays exhibit feeding problems (Gouge & Ekvall, 1975; Palmer & Horn, 1978). So how do parents evaluate whether their child's problems will resolve in the absence of intervention (will the child "grow out of it?") or whether the feeding problem will persist and/or worsen? As professionals, we must guide parents to differentiate between those children with serious and potentially life threatening feeding problems from those children with the run of the mill eating difficulties common in childhood.

Typically eating infants will accept breast milk or formula readily after birth. Some infants have difficulty initially latching on or may have problems initially coordinating the suck, swallow, breathe response. However, these difficulties should resolve relatively quickly (i.e., within a few weeks) (Rogers & Arvedson, 2005). Baby foods usually are introduced between four and six months of age. Some tongue thrusting may persist and the infant may have trouble at first retaining the bolus in the mouth. Simply replacing the expelled bolus back into the infant's mouth should provide sufficient practice to eliminate the tongue thrusting over time. Most children transition to mashed table foods by about 12 months and show taste preferences by 18 months.

Concerns arise when the infant consistently rejects breast or bottle feedings, particularly if refusal is accompanied by no or slow weight gain. Problematic feeders may reject breast or bottle feedings while awake, but will feed more readily while asleep. Lengthy feedings consistently greater than 20-40 minutes also may be another sign that a feeding problem looms on the horizon. Feeding problems may persist for children who have problems transitioning to baby, mashed or table food.

As the child progresses from a liquid to a solid diet, most typically eating toddlers will prefer some foods over others, and food likes and dislikes may be unpredictable from day to day or week to week. Even though many children would rather play than eat, most children will respond to their internal cues and eat when hungry. Thus, even though a child may go several meals with inadequate intake, over the course of longer periods of time (e.g., a week), the child will consume sufficient calories and nutrients to gain weight and grow (Birch, Johnson, Andersen, Peters, & Schulte, 1991; Davis, 1939).

Problematic eaters will have a much more limited diet with strong likes, which are limited to very few foods, and strong dislikes. These preferences are manifested in that presentation of non-preferred food is accompanied by consistent, dramatic, emotional reactions which are out of line with the reactions of typically eating toddlers to presentation of non-preferred foods. Problematic eaters often will eat only a certain texture of food (e.g., smooth, creamy foods) or will drink only liquids and refuse most solid foods.

The most salient and easily measured signs of a feeding problem are if a child (a) fails to gain weight or (b) does not grow along his/her

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From the Chair

Sharon Wojnaroski, MA, RD

Aloha to our new and returning members. It is with anticipation and enthusiasm that I look forward to working with you this year. Already there has been much accomplished by your executive committee as we have prepared for FNCE in Hawaii, as well as planning ahead to Philadelphia in 2007. Additionally, the standards of Practice in Behavioral Health were published in JADA, and we are introducing a Resource Guide for Dietetics Professionals practicing in Behavioral Health at FNCE in Hawaii.

FNCE in Hawaii is in the next few weeks. We hope you will take advantage of the activities we have planned. Our priority session will be Monday, September 18 at 7 AM.

Applicable to all four of our areas of practice ***Our Bodies, Ourselves: How to Discuss (or Not!) Our Size With Clients*** promises to be both practical and informative as we learn effective techniques to address body size issues directly with clients.

Stop by our booth at the DPG showcase, Monday September 18, between 10:30 AM and 1 PM. Let us know who you are and pick up your member ribbon. You will also be able to purchase our new Psychiatric Nutrition Therapy Resource Guide on CD at our special FNCE member pricing.

We hope you are taking advantage of the free continuing education articles in the Newsletters, and the networking opportunities on the listserv. Be sure to consider having your name placed on the public map on our website. If you have not done so, check it out at ddpd.org.

I've had the good fortune to work with a number of DDPD Executive Committees since my first term as a resource professional in 1992. Each of the leaders has enriched both my personal and professional life as a mentor and a friend. Since there are too many to name them all, I will just say THANK YOU to all of them.

Sharon Wojnaroski

Feeding Difficulties: What to look for and how to help

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own curve. Specific indicators are a decrease in expected rate of growth based on the child's previously defined growth curve or if the child's weight crosses more than two major percentiles downward. Children should gain weight consistently, thus if the child experiences three consecutive months of weight loss, it is probably time to initiate treatment. Other concerning indicators of a feeding problem are (a) dehydration or malnutrition, which result in emergency treatment, (b) the presence of a nasogastric (NG-) tube with no increase in the percentage of calories obtained via oral feeding for 3 consecutive months, (c) chronic, lengthy meals consistently greater than 20-40 minutes, (d) unusual or inappropriate mealtime conditions (e.g., will only eat one brand of a certain food), (e) high levels of inappropriate behavior (e.g., tantrums) during meals, (f) feeding habits that differ significantly from that of the family or negatively affect social life (e.g., the child can't go to a birthday party), (g) feeding that is not age appropriate (e.g., a five-year-old who does not eat table texture foods), (h) over-dependence on single or limited source(s) of nutrition, and (i) high levels of parental or family stress during meals.

There are a number of factors, which are associated with increased risk of a feeding problem. These risk factors include premature birth, cardiac and/or lung problems, history of gastrointestinal problems (e.g., reflux disease), food allergies, and developmental disability (Braun, & Palmer, 1985; D'Antonio, 1979; Dodrill, McMahon, Ward, Weir, Donovan, & Riddle, 2004; Harris, 1986). Medical problems are hypothesized to increase the risk of feeding problems when the medical problem causes eating to be painful (e.g., in the case of reflux) (Hyman, 1994). The child then associates eating with pain, rather than pleasure, and develops behavior such as batting at the spoon, head turning, or crying to "make the spoon go away" (i.e., avoid eating). If the child's refusal behavior results in meal termination, the child learns that, "If I bat at the spoon and cry, the food goes away." Thus, the child is more likely to engage in refusal behavior in the future. Even after the medical problem is treated, if the child continues to refuse food, he/she does not learn that eating is no longer painful or unpleasant.

In addition, children with chronic medical problems often are subjected to invasive diagnostic tests and procedures that may involve manipulation of the face and mouth (e.g., laryngoscope), which cause pain or are unpleasant. Therefore, the child may associate the presentation of objects to the face and mouth (e.g., a spoon) with these early negative experiences. Parents of hospitalized and medically fragile children often report oral aversions that affect feeding and other behaviors associated with the face and mouth (e.g., tooth brushing, face washing).

Refusal to eat may either cause or exacerbate oral motor problems. That is, if the child does not eat, then he/she does not practice nor develop the skills needed to be a successful eater. Thus, if food does enter the child's mouth, the child may not be able to manage the food effectively or efficiently. The child's inability to effectively manage the food from an oral motor perspective may result in choking or gagging, which may further reinforce the child's experience that eating is unpleasant.

Obviously, refusal to eat generally is associated with decreased volume and caloric intake over time. If the child's intake decreases over time, he/she may learn to tolerate these low caloric levels. Many parents of children with serious, chronic feeding problems will report that their child can "go days" without eating. The child's ability to withstand conditions that would ordinarily result in extreme hunger for most of us may either be a cause or a contributing factor to the child's feeding problem. (i.e., the child does not respond to or does not experience hunger the same as typically eating individuals).

An important first step in the successful treatment of children with feeding problems is to set goals for treatment in measurable terms. Goals should be individualized for each child (see sample goal sheet in Appendix A). Some examples of measurable goals might be to "increase oral intake of solids and liquids to 50% of the child's nutritional needs." This might be an appropriate goal for a child who is 100% gastrostomy (G-) tube dependent

when treatment begins. Another goal might be to increase acceptance of bites of food to greater than 90%. This might be an appropriate goal for a child who refuses bites of food.

Defining appropriate and problem behavior in measurable terms must go hand in hand with goal setting. It won't be possible to determine if you have met the goal, if the behavior is not defined in a way that can be measured. So for example, if the goal is to increase acceptance of bites of food to greater than 90%, we must define acceptance in a way that it can be measured. An example of a definition of acceptance might be that the child opens his/her mouth and allows the bite to be deposited into his/her mouth within 5 seconds of the initial presentation of the bite. Defining behavior in measurable terms helps parents to focus on which behaviors contribute to appropriate and problematic eating and to understand which behaviors are the focuses of treatment. Once behavior is defined clearly, it then can be measured in a way that will allow you and the parent to determine whether the behavior is improving, worsening or staying the same.

Once goals are set and behavior has been defined in measurable terms, we need to help parents develop a data collection system that will allow them to measure the defined behaviors, thus allowing us to examine the pattern of these behaviors. Data collection systems should focus on the target behaviors and should be simple enough for the parent to collect data accurately, but sufficiently comprehensive to allow assessment of progress toward goals. For example, if the target behavior is acceptance of food, then data could be collected on a bite-by-bite basis with the parent recording the occurrence of the target behavior. The data collection system (see the example in Appendix B) might include a column to indicate when bites were presented and a column to indicate if the child accepted the bite (using the definition of bite acceptance as described above).

Ideally, data collection should begin prior to initiation of treatment. An accurate baseline is essential to be able to evaluate progress. Memory is no substitute for data from direct observation, as memory and anecdotal observation are notoriously unreliable. Treatment then can be initiated once baseline data collection is complete. The quantity of baseline data is less important than establishing a stable level of behavior from which to evaluate progress. Thus, if behavior is variable during baseline, more observations will be necessary than if the behavior is relatively stable and predictable. The goal of the data collection should be to be able to predict what will happen next. For example, if the child consumed 450-525 calories for four consecutive days, then it is likely that caloric intake will be in this same range on the 5th day. By contrast, if the child consumed 1100 calories on day one, 450 calories on day two, 560 calories on day three, and 890 calories on day four, then the caloric intake for day five would be much more difficult to predict. Thus, data collection probably should continue in the latter case before treatment is initiated.

It is important to remember that children with food refusal have a different history or experience with food than typically eating children. That is, even though many typical ly eating children will have bouts of feeding problems from time to time, their problems resolve without intervention. By contrast, the feeding problems of children with food refusal often persist and worsen over time (Lindberg, Bohlin, & Hagekull, 1991). Therefore, the techniques or recommendations that are used for typically eating children may not apply or may not be effective for children with food refusal. Thus, we can't expect a child with a feeding problem to respond as quickly or easily to commonly recommended strategies....and in fact, some commonly recommended strategies used with typically eating children actually may worsen the feeding problems of children with feeding problems (Piazza, Fisher et al., 2003).

Most children with very severe feeding problems probably have some underlying cause for their feeding disorder. Thus, a thorough medical work-up should precede any aggressive attempts to treat the feeding problem. Aggressive oral feeding in the context of an ongoing medical problem may exacerbate the feeding problem. For example, if the child has untreated reflux and eating continues to be paired with pain, it is unlikely that therapeutic attempts to increase intake will be successful and may be likely to worsen the child's refusal behavior. Therapeutic interventions can begin once medical problems are either ruled out or resolved.

An important consideration in terms of developing treatments for children with chronic feeding problems is that children with chronic feeding problems may not respond to strategies that are recommended commonly for children with milder or more transient feeding problems. Therefore, considerable thought and monitoring should follow any recommendations that are given to parents.

Parental cooperation obviously is an important key to successful treatment. Parents generally do not cause their child to have a feeding disorder, and they should be reassured of this. However, the way that parents respond to a child's inappropriate behavior during meals can affect refusal behavior. In fact, as mentioned above, strategies that may be helpful for children with transient or mild feeding problems may actually worsen the behavior of children with more severe or chronic feeding problems. To further examine the factors that may affect refusal behaviors, we conducted studies to systematically examine how parental behavior affects child inappropriate behavior during meals.

In one study, we observed children with feeding problems and their parents during meals (Piazza, Fisher et al., 2003). We observed that parents responded to child inappropriate behaviors (e.g., crying, head turning, batting at the spoon) with one or more of the following consequences: (a) allowing the child to take a break from eating or stopping the meal entirely, (b) coaxing or reprimanding (e.g., "Eat your peas, they are good for you"), or (c) providing the child with a toy (distraction) or preferred food. We then evaluated how the consequences used by parents during meals affected child behavior (i.e., did child behavior worsen or improve?) during four test conditions. These test conditions were designed to simulate what the parents were doing during meals, but in a way that would allow us to measure whether child behavior improved or worsened when a particular consequence (e.g., meal termination) followed child inappropriate behavior. During the attention condition, the therapist provided attention in the form of coaxing and reprimands (e.g., "Eat your peas, they are good for you") when the child engaged in inappropriate behavior (e.g., batting at the spoon, head turning). During the escape condition, the therapist removed the spoon and allowed the child to take a break from eating when the child engaged in inappropriate behavior. During the tangible condition, the therapist attempted to distract the child by giving the child a toy or an alternative food item after the child engaged in inappropriate behavior. In a control condition, the therapist ignored inappropriate behavior and interacted with the child throughout the meal independent of inappropriate behavior. The results of the assessment showed that the consequences commonly used by parents to encourage eating (e.g., coaxing, allowing breaks from eating, distraction) actually worsened the inappropriate behavior of 67% of the children. It is important to note that the study showed that child behavior worsened when parental responses followed child inappropriate behavior. For example, if the child cried and the parents responded by coaxing (e.g., "You like this food, it's yummy"), the child was more likely to cry again in the future. Similarly, if the child refused to eat and the parent ended the meal (e.g., "You must not be hungry, so you don't have to eat"), the child was likely to refuse to

eat again in the future. Also, if the child batted at the spoon and the parent tried to distract the child (e.g., "Look, I turned on the cartoons"), the child was likely to bat at the spoon again in the future. This point is elaborated on because these are responses that we commonly use with children during meals. Nevertheless, these responses were found to worsen the behavior of children with chronic and/or severe feeding problems. Of additional importance is that the results of this study indicated that the worsening of child behavior occurs when parental responses follow child inappropriate behavior. These findings have important implications for treatment.

First, we as professionals want to ensure that parents are not responding to child inappropriate behavior with any of the consequences described above. That is, we should discourage the use of coaxing, reprimanding, meal termination, or distraction following child inappropriate behavior. This recommendation is easier said than done. Parents frequently have a difficult time refraining from correcting their child when he/she engages in inappropriate behavior at the table. In addition, most parents will report that they have been advised that when the child gets hungry, he/she will eat. Thus, asking a parent not to coax, reprimand, distract, or terminate the meal may be counterintuitive from the parent's perspective.

Alternative strategies include having parents discuss eating, nutrition, etc. with their children. These discussions should occur outside of mealtime to minimize the likelihood that the parent will use coaxing (e.g., "This is good for you") when the child engages in inappropriate behavior during the meal. An additional strategy is setting mealtime rules (e.g., "You may get out of your chair and be finished after you take two bites of each food on your plate"). The parent should explain the mealtime rules prior to the start of the meal. That way, the parent feels like he/she has had the opportunity to talk to the child about the expectations for the child's behavior during the meal. Hopefully, the parent then can refrain from coaxing or reprimanding once the meal begins. In addition, parents can be taught to give reminders to eat on a time-based schedule (e.g., once every 5 minutes). Time-based reminders are less likely to worsen child behavior relative to reminders that follow child inappropriate behavior.

Some parents will report that distracters actually improve child behavior during meals, and this may be true. In some cases, the presence of distracters during meals is associated with fewer child inappropriate behaviors (Reed et al., 2004). Distracters can be effective for reducing child inappropriate behavior if the distracters are available independent of (as opposed to following) child inappropriate behavior. The problem with distracters is that often parents will use them only when the child engages in inappropriate behavior. For example, the parent will turn on the television when the child starts crying. If parents report that distraction is a critical component to "keeping the peace" during the meal, then the distracters should be present at the beginning of the meal and remain available independent of child inappropriate behavior throughout the meal. Again, providing the distracters independent of inappropriate behavior is less likely to worsen child behavior relative to providing distracters when the child engages in the inappropriate behavior (e.g., turning on the television when the child starts crying).

Finally, a more controversial issue has to do with terminating the meal if the child refuses to eat. Most professionals would argue that if the child is hungry, he/she will eat. That is true of typically eating children who gain weight appropriately. However, children with feeding problems, who do not gain weight appropriately, obviously are not responding to their internal cues to eat. Therefore, we can't always allow children with feeding problems to rely on their internal cues. The simplest way to address this issue is to determine the meal length ahead of time. Thus, the meal can end according to a schedule rather than following child inappropriate behavior. Similar to the examples given above, a time based meal is less likely to worsen child inappropriate behavior relative to ending the meal when the child engages in inappropriate behavior.

Once these general mealtime recommendations have been implemented, you can begin to focus on more individualized aspects of a given child's feeding behavior. Parents should be encouraged to develop a few simple mealtime rules. The precise rule may be less important than the fact that the rule can be followed through with consistently. If rules are not followed, the child simply learns to "wait the parent out." That is, the child knows that if he/she waits long enough, the parent will give in and the rule will not be followed. Thus, parents need to be encouraged to start with rules that they can follow through on, even if they are simple rules that may not make a big difference in the child's behavior immediately. The initial goal simply would be to teach the child that the parent will follow through with a rule once the rule is in place.

Some parents give up on presenting foods that the child refuses consistently. Thus, parents should be encouraged to continue presenting a wide variety of foods, including some the child has eaten in the past and some the child typically refuses. Remember, however, studies showing that exposure is an effective method of increasing variety generally are conducted with children who willingly taste novel foods and tasting the food (as opposed to smelling it or just having it in front of you) appears to be a critical component for exposure to be effective (Birch & Marlin, 1982; Davis, 1928). We also need to be careful about taking away the child's preferred food(s), particularly if those food(s) are the only ones the child will eat and which account for the majority of the child's caloric intake. For example, we often recommend simply throwing away the bottles for children who are bottle dependent with the idea that if the bottle is not available, the child will eat or drink what is presented. Again, that recommendation is fine for children who are experiencing mild or transient resistance to the introduction of new foods or liquids. However, for children who have evidenced more serious feeding problems, taking away the child's only source of nutrition may have disastrous consequences. Prior to embarking on such a strategy, make sure you discuss parameters for such a program. For example, it would be important to have some weight and/or hydration guidelines to use. If the child falls below a minimal acceptable consumption level of fluids or loses more than an acceptable level of weight, the preferred food or liquid may have to be reinstated. Even though it is preferable for the parent to follow through and not give in, the risk of excessive weight loss or dehydration has to be balanced with issues of consistency and follow through.

Similarly, people often ask about strategies like "making the child eat everything on his plate." This strategy typically is not recommended with the rationale that we don't want to teach the child to overeat or to ignore internal hunger and satiety cues. Again, the issues of overeating and internal cues are probably less of an issue for children with severe feeding problems who don't seem to be responding to internal cues anyway. The bigger issue is that parents rarely follow through on these types of contingencies. The parent may make the child sit at the table for a long period of time on one occasion, but is not likely to do so consistently. We typically recommend that parents use the rule of thumb, "Don't start what you can't finish."

Aside from these more general recommendations, that may apply to many children, one of the best ways to develop treatment for any individual child is to evaluate what the child will do at present and use that as a starting point. For example, if a child refuses to sit at the table when non-preferred food is present, then requiring the child to put a green bean to his or her lips is probably not a wise first step in overcoming the feeding problem. In this case, you may want to start by developing a

rule that the child has to sit at the table for some brief period of time with the non-preferred food present on the table. After the child will consistently sit at the table in the presence of the non-preferred food, other steps geared toward the final goal (i.e., consumption of non-preferred food) can be gradually introduced. If the child will eat some foods while watching television, then you may want to introduce new foods while the child is watching television. If the child only will eat smooth foods, you may want to introduce new foods at a smooth texture and then increase texture gradually. Even though these initial steps or rules may not be age, developmentally, or socially appropriate, they are only starting points in treatment. The goal is to find a starting point that will allow the child to be successful. Once you have achieved some success, you can begin to change the eating context to make it more appropriate.

People always ask whether rewards should be used during meals. The issue of rewards is another controversial and misunderstood topic in the context of eating. A rationale that is used for not using rewards is that the child will learn to value the rewards and not the food. However, a counter to that is that if the child is not eating and not gaining weight, then obviously, he/she does not "value" food anyway. And if no other strategies have been effective for increasing intake up to this point, then adding a reward for appropriate eating may be a strategy to consider as it may prove an effective method for increasing intake. Rewards will only be effective, however, if they are used correctly. First, the reward should be something for which the child is willing to work. Second, a reinforcement or reward procedure usually is more effective if the rewards are varied rather than using the same reward over and over. Third, rewards should be relatively immediate and obtainable. For example, it typically is more effective to allow the child to play with a preferred toy for a brief period following acceptance of a bite of food than to promise to take the child to Disney world if he/she "eats well." An effective reward procedure should be used consistently; that is, whatever the initial rule is for earning rewards that the child is told should be the same throughout the entire meal and not change during the meal if the child does something the parent doesn't like. Finally, the child should not have access to the reward outside of meals. After all, why work for something if you can get it for free? Implementing a reward procedure doesn't mean that the child will require rewards to eat for the rest of his/her life. Like any other treatment, rewards can be removed gradually from the meal over time. For example, you might start with allowing the child to play with a toy for 20 seconds each time he/she accepts a bite of food. You might then increase the requirement to 2 bites, then 3 and so on, until the child consumes an age typical portion of food and then leaves the table and plays (as is the case with most typically eating children).

Most importantly, there is no quick fix for children with severe feeding problems. Successful treatment should include clearly defined behaviors, objective and measurable goals, collection of baseline data, and ongoing evaluation of treatment effectiveness using your data collection system. Parents should be encouraged to develop rules they can follow through with and implement procedures consistently. These strategies offer general guidelines which can successfully be used to help parents effectively manage their child's feeding difficulties.

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Appendix A

SAMPLE GOAL SHEET

1. Increase total P.O. from (kcal _____ to kcal_____) or from ___% to ___%
2. Increase liquid P.O. from (kcal _____ to kcal_____) or from ___% to ___%
3. Increase texture from _____ to _____ (e.g., from baby food to mashed)
4. Increase weight from _____kg to _____kg
5. Decrease tube feeding from (kcal _____ to kcal_____) or from ___% to ___%
6. Decrease bottle feeds from ___% to ___%
7. Increase acceptance of bites of food to greater than ___%
8. Decrease inappropriate mealtime behavior to ___% of meal

Appendix B

SAMPLE DATA COLLECTION SHEET

Instructions: Record the date and meal that data is being collected for in the first two columns. Circle P when a bite/drink is presented to the child. Circle 5 if the child accepts the bite/drink within 5 s of the initial presentation of the bite/drink. Circle 3 if it takes the child greater than 5 s after the initial presentation of the bite/drink to accept the bite/drink. Circle I if the child engages in inappropriate mealtime behavior (e.g., turns his/her head away, pushes the spoon/cup away) during the bite/drink presentation. Circle E if the child spits out the bite/drink after he/she accepts the bite/drink. Circle N if the child cries during the bite/drink presentation.

Date	Meal						
	Breakfast	P	5	3	I	E	N
		P	5	3	I	E	N
		P	5	3	I	E	N
		P	5	3	I	E	N
		P	5	3	I	E	N
		P	5	3	I	E	N
		P	5	3	I	E	N
	Lunch	P	5	3	I	E	N
		P	5	3	I	E	N
		P	5	3	I	E	N
		P	5	3	I	E	N
		P	5	3	I	E	N
		P	5	3	I	E	N
		P	5	3	I	E	N
		P	5	3	I	E	N
	Dinner	P	5	3	I	E	N
		P	5	3	I	E	N
		P	5	3	I	E	N
		P	5	3	I	E	N
		P	5	3	I	E	N
		P	5	3	I	E	N
		P	5	3	I	E	N

Website Update!

A link to the *Standards of Practice and Standards of Professional Performance for Registered Dietitians in Behavioral Health* has been posted to our website. Check out this valuable resource for our area of practice. (Available to ADA Members Only) http://www.ddpd.org

FNCE Happenings!

Sponsored Session

Don't forget to join us at FNCE for our Sponsored Session Monday at 7:00-8:30 a.m., Hawaii Convention Center, Room 316ABC!

Our Bodies, Ourselves: How to Discuss (or Not!) Our Size With Clients

Learn effective techniques to address body size issues directly with clients. Develop comfort with your expertise no matter your size and influence change in your clients by modeling self-acceptance and care.

FNCE Opening Night Event

Look for us at the FNCE Opening Night Event at the Sheraton Waikiki Hotel in Honolulu!

Look for your fellow DDPD Members and Executive Committee at the Opening Night Event on Saturday, 7:00-9:30 p.m. Tickets are $50 with your conference registration. We hope to see you there!

Visit the DDPD Practice Group Booth at FNCE

Stop by to visit DDPD at the at the DPG Showcase, Monday, September 18, from 10:30am to 1:00pm, in the Ala Halawai Concourse (level 3) of the Hawaii Convention Center, booth #37.

Resource Available: *The Basic Nutrition and Doctor Prescribed Diets Resource Guide*

Paula Cushing, RD, Sherry Kyker, RD and Carolyn Foster RD

Three regional dietitians who oversee nutrition services in the Home and Community Based Wavier Program in the state of Tennessee developed The Basic Nutrition and Doctor Prescribed Diets Resource Guide. This resource guide serves as the foundation for a training that is offered to service recipients, families, conservators, residential agency staff, direct support professionals, case managers/support coordinators, advocates, and clinicians. The trainings are provided at the agency's site upon request and also offered monthly at each regional office.

The guide is divided into four main sections: Overview of Basic Nutrition, Overview of Doctor Prescribed Diets, Dietary Tools, Supports, and Guidelines. The Guidelines section includes menu planning, grocery shopping, meal preparation, and what to do when a diet is not working for a consumer. Dietary tools and supports include food budgeting guidelines, food safety and proper food storage, guidelines for eating out, a provider checklist, and a checklist for identifying issues that may be preventing dietary compliance. Additional nutrition resources include high fiber and high calorie recipes, healthy meal preparation, portion control, a restaurant guide, exercises, obtaining accurate body weights, and sample menus and forms.

We are quick to remind each participant that this guide is not intended to take the place of a dietitian's services but to instead provide them with guidelines and additional support needed to implement a doctor-prescribed diet. Many of the community dietitians in our program utilize the resource guide's materials in their trainings. The guide and training has been received with great enthusiasm, and has proven to be a much-needed resource for people providing services and supports to people with intellectual and developmental disabilities.

The Basic Nutrition and Doctor Prescribed Diets Resource Guide is available by going to our website at: http://www.state.tn.us/dmrs. Click on Providers and then look for *"Basic Nutrition Resource Guide"* under Resources.

For more information Email: Paula.Cushing@state.tn.us

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