Transcription – *Eating Can Be Hard*

CM: We think of feeding as just something that kids naturally do, but oftentimes it needs to be guided. It’s important for families to understand that if those skills aren’t successful, they didn’t do something wrong; all kids need support in different ways, so just like you may need support with learning handwriting, or reading, or throwing, you know [0:19] feeding skills can be the same way. For most of our families, the thing they tell us is, “We thought it was going to get better, so we waited, and it didn’t get better until we started working on it.”

CR: Welcome to Adjusting the Sails, a podcast for parents, caregivers, and service providers for children with disabilities. I’m your host, Courtney Ringstaff, Paths for Parents program manager, and this is my co-host, Melina Danko.

MD: Hello everyone.

CR: Melina is the Communications Officer at the Center for Excellence in Disabilities and the Project Director for the West Virginia Family to Family Health Information Center.

MD: We’re so glad you’ve joined us.

CR: I am a licensed social worker in Morgantown, West Virginia, and I’ve created this podcast to be a platform where parents, caregivers, and service providers can come together, exchange information, educate one another, and find support and connection through the relatable topic discussions. We cannot change the direction of the wind or the strength of the storm, but together we can adjust the sails.

CM: I’m Cassie Miller. I’m a Speech Language Pathologist here at the Center for Excellence in Disabilities. And here at the Center I am the Director for our Feeding and Swallowing Clinic, and I also teach some coursework in Disability Studies. My career has been about 15 years focusing specifically on Feeding and Swallowing.

CR: We’ve invited you here today to talk about what makes a child a picky eater, so we’ll just start with that question, “Why are some children picky eaters?”

CM: Okay, so [2:16] I think the biggest answer to that is we don’t always know, but we do have some evidence and some data that tells us why. And [2:23] the first thing I wanted to talk about is that there’s picky eating – which is a normal part of development; we expect that from most kids – and then there’s problem or selective eating, and those look different. So [2:34] about 60% of all kids will experience some kind of picky eating. And this usually occurs around 18 months or so and then peaks at about 3 years old, and then they start to expand again. And that usually happens when kids realize they have choice. “No, I do not want goldfish anymore; I’ve realized there’s this amazing thing called Toaster Strudels, and I want Toaster Strudels.” Different than our kiddos who are selective or problem feeders who may cut out entire food groups, or who may be eating like [3:08] 10 or less foods at a time. Kiddos who are developmental picky eaters, usually you can find something for them to eat. If you go to a restaurant, or you go to a family’s house, there’s something they might eat – bread, or crackers, or something. For our selective or problem feeders, they would choose to not eat over eating a food that seemed to them unsafe. So those are kind of [3:30] 2 different things. They’re both things that you can use strategies to work on, but they’re a little bit different. I think the other thing to remember is: feeding doesn’t always just get better on its own. It’s developmental, and sometimes we have to teach those skills. So I just wanted to talk a little bit to families about reasons that eating can be hard or why we’re on a selected diet. The first thing we always look at is medical and psycho-social, so is there a medical diagnoses like a history of reflux or a long NICU stay that may have impacted a child’s ability to eat? The other one is: has there been a trauma? Do we have you know[4:08] open food access? some maternal factors during pregnancy? So we always look at those medical and psycho-social factors for everybody. And [4:16] then there’s 3 other ways that a Feeding Team looks at eating: sensory, developmental, and behavioral. So [4:24] I was just going to talk about those just [4:25] briefly so that families can…can kind of [4:28] recognize what those 3 are. First is sensory – it’s the way that we interact and respond with our environment. It’s different for everyone, and our sensory systems guide these interactions, and for some kids their systems may respond a lot to food or they may respond less, and this really impacts what foods they’re able to eat successfully. And [4:52] we know our main senses, right? Sight, hearing, smell, taste, touch. Those all impact eating. But for kids there’s other influences as well, and for one of those is a sense called interception – and [5:02] that’s the ability for us to recognize what our bodies are telling us. And that really impacts feeding, for example, if I have a stomachache, for me I might be like, “Oh, maybe I didn’t drink enough water; maybe I’m having some constipation…” But for kids they may interpret that as “Food is bad.” Right? [5:21] Similarly, when they’re hungry they may think like[5:24], “Oh my gosh, I don’t…[5:25] I’m not sure what to do.” And not recognize that they need to eat. So being hungry and being satiated, you know,[5:32] are not always easily recognized for kiddos, so…[5:35] so that sensory component you know [5:36] is a big one for kids. The other one – development – we think of feeding as just something that kids naturally do, but oftentimes it needs to be taught or guided. Swallowing emerges in utero at about 12 weeks, and it continues to develop throughout pregnancy and then into childhood; so that first cognitive test of “suck, swallow, breathe”, you know,[5:57] kids aren’t always successful with that and sometimes they need intervention to make those skills develop and successful for them. I think it’s important for families to understand that if those skills aren’t successful, they didn’t do something wrong; all kids need support in different ways so just like you may need support with learning handwriting, or reading, or throwing, you know [6:17] feeding skills can be the same way. And that can look like core stability, learning how to move your tongue, getting your lips closed, you know [6:24] all those are developmental skills um [6:26] needed for eating. And the last piece of why some kiddos are picky eaters or maybe selective eaters is behavior; and every single thing we do is a behavior, so when I talk about behavior I don’t mean it as a negative thing – like they’re having bad behaviors – but for some kids something in their environment impacts how they respond to eating. So one example could be that the first time they get peas, the kiddo gagged and the caregiver took the peas away and was like, “Oh my gosh, I hope you’re okay! You never have to have peas again. Peas are bad,” and they give them the food that they love the most. Right? [7:05] And so then for the next food – maybe peaches – the same thing happens: they gag, “Oh my gosh! Peaches are so bad. No more peaches. Here’s your favorite food,” and then that kiddo’s like, “Aha! I’m going to do a little gag, and then they’re going to give me my most favorite thing.” And so over time those kinds of responses can shape what a kiddo eats. But it’s not the fault of the caregiver, right? Because as families, we want to sit and have mealtimes together – super social – and we want our kids to be happy and safe, and so sometimes for behavior we just provide some education to families like: when kiddos are born, the thing that their tongue does is move in and out. They haven’t learned to move their tongue side-to-side yet; and so when you give them those first foods, most of the time they spit them right out the front um [7:50] not because they don’t like it but because they don’t know what to do with it yet, and so they’re developing that skill to do that. And so those are kind [7:58] of some of the reasons why kiddos can be picky eaters or selective eaters. And we often can’t tease it out to be one single thing, but what we do know is we look and assess all these areas, and then we provide intervention and education to help promote an expanded diet. Because for most of our families, the thing they tell us is, “We thought it was going to get better so we waited, and it didn’t get better until we started working on it.” So really actively working on feeding is the most important piece, cause sometimes we can’t tease out exactly why. We know those couple things, right? [8:34] – sensory, development, medical, social, behavior – it’s some combination of those, but working on them is what’s important.

CR: For parents who do consider their child to be a picky eater, how can they support that child’s expansion and exploration into new foods?

CM: So family meals are super important in this situation, and a family meal doesn’t have to look like what we saw on sitcoms in the 80’s, right? [9:03], or the 90’s. A family meal can look like whatever it looks like for your family – where people are sharing some similar food in the same space. So if you’re sitting on the couch together, or you’re sitting on the floor together, or you’re, you know, [9:16] at a baseball game watching a sibling play – whatever that looks like. Um [9:20] so just sitting together. Families, parents, siblings are the biggest teacher for these kiddos who are struggling to add different foods to their diet. Just starting in that space will allow different exposures to foods and positive associations with foods. So they see other people eating the food, they’re enjoying the food, they’re not gagging with the food, they’re kind of [9:41] talking and laughing with the food. And the other piece is to really understand that parents and kids have different responsibilities during mealtimes; and when those get switched, it can get a lot harder. So parents decide the “what”, the “when”, and the “where.” Right? [9:58] So parents decide what we’re eating, when we’re eating it, and where we’re going to eat it. And the kids get to decide “if” I’m going to eat it, and “how much” I’m going to eat it. Now that gets interesting for families when their kids like, “I am absolutely not eating this food you made. No way! I’m not eating that.” So what we kind of [10:17] have our clinic families do – or when we’re encouraging families to expand – when you make their plate, you can give them teeny, tiny specks of what the family is having and then make sure you’re giving them some safe foods too. Um so [10:31] if you offer them… [10:32] if they prefer macaroni and cheese and grilled cheese, and those are the foods that they like, then I would put those on the plate and then – say the family is having broccoli and chicken – you can put a teeny, tiny amount of that new food on their plate just for them to start to get an exposure. And when you’re starting this, you don’t even mention it. You just put it on the plate, and there it is; and they look at it and – “I really love how you looked at that broccoli! Great job! High five!” – not even mentioning that it’s time to eat it. Um [11:00] and some kids, having it on their plate is too much; so you might even have to put it on a plate kind of [11:05] beside them, and you can say, “I really like how you let that sit on a plate beside you.” And we’re not going to focus on that they’re not eating it, we’re going to really focus on how they’re engaging with the food and the new food. “Oh, it’s great and you let it sit there. Great job!” And just slowly over time integrating those new foods. For kids it takes about 30 times for them to decide if a food is something that they’re willing to accept. So you give it to them once, and they spit it out; that’s one out of 30. So 30 times is a lot; and it’s not 30 bites, it’s 30 exposures - so 30 meals. Um that…[11:38] that can take a lot of time.

CR: Cassie, you had mentioned that to me previously in conversation, and it got me thinking about my own child; and no wonder he prefers chicken nuggets or pizza, for example, because at any restaurant that’s what’s on the kids’ menu. Anytime we go anywhere else, that’s what’s being consistently presented to him.

CM: A hundred percent! And when you go to a birthday party or preschool, or you’re cooking something quick because you have something else going on, those are the go-to foods, so those are foods that a lot of kids like. I think it’s important too to recognize small exposures and small successes. If your kid is sitting beside you and they usually hate broccoli and they touch your broccoli, that’s a success – “Yay! Great job! You touched the broccoli. I love it!” I think we get caught up in, “Oh my gosh, they didn’t eat all the broccoli. They didn’t eat exactly what we ate.” If we go from ‘they won’t even let it be near them’ to ‘expecting them to completely eating it’, then we’re always going to feel like a failure. I would feel like a failure as a clinician, and I think families would really struggle with that. And so, [12:41] just recognizing what a success might be – just letting it be there and them not throwing it across the room – success! A+ The other thing that works really well for kids sometimes is: parents always know what kids love; so if they love bubbles, kind of [12:54] have some bubbles in your pocket and if they’re at the table and they look at the bean or they touch the bean, blow some bubbles. Do we want to blow bubbles at the table forever? No. But what we’re doing isn’t working, so we have to change something. So if we just keep doing the same thing that we’re doing, we’re going to get the same result. Right? [13:07] And we know that a lot of kids don’t just grow out of this, so we need to have some routines in place for them to expand.

MD: I’ve seen you use strategies like after-exposing and it’s okay to be on the plate, that they can smell it. Like [13:23] what are the next steps? Then smelling it, licking it, kissing it, taking one bite, you know [13:27] those kinds of things?

CM: Absolutely. So science behind feeding or working on picky eating really talks about gradual exposure. And once you kind of [13:36] get the pattern down, you recognize like [13:38], “Oh, I totally get that.” So first it’s just that they know the food is around. Some kids don’t even tolerate the smell of food cooking in their space, so some families we have to start there. But with a lot of kiddos they start with it sitting there, and then they look at it, and then they smell it, pick it up, right? [13:59], bring it to your nose, put it back down, take a break, pick it up, bring it to your lips, maybe give it a kiss, put it back down, pick it up, touch your tongue to it, put it back down, then bite it with your teeth, put it back down, you know [14:13] and then we move towards – I use like [14:15] – send it to your belly; because sometimes kiddos have heard, “Eat it, eat it, eat it, eat it” so many times and 2 things have happened: they’ve been told to eat it lots of times and they didn’t have to, so they see that as kind of [14:26] a suggestion…they’re like, “Yea, I know you’re saying that, but it doesn’t really mean anything.” Or “Eat it” means that you have to eat all of this thing that you don’t like, and it becomes overwhelming. So I start with little specks of food – I mean like the tip of a pen amount. My speck and your speck might look different, cause it’s not a super scientific term, but we really go teeny, tiny when I’m sitting there cutting them – I’m like, “Oh my gosh, all this schooling and this is what I do: cut these tiny pieces.” But that helps a kiddo have success. So, yea, that gradual approach is really the treatment and the science behind picky eating is really based on this gradual exposures.

CR: So when would we know that a child needs to see a specialist? When would we know it’s time?

CM: Okay,[15:08] so let’s just talk about just some red flags in general of feeding. The first thing, I think, that happens in a family is that the parent recognizes that something is going on. Um [15:18] parents are the biggest experts for their kiddo, so they often just have this gut reaction that something is off. For parents who have multiple kiddos, they might recognize that eating looks different for this child. Or if it’s a new mom they might be on a blog, or they might you know [15:33] be talking to someone else and the…[15:35] they’re just recognizing that eating looks different for their kid. But specifically, any time a kiddo had a skill or they’re able to do something, and they’re not doing it anymore. Right? [15:46] So they were able to do this thing with eating: chew it up, swallow it, move their tongue a certain way, and they stopped doing it. Red flag. Right? [15:54] If they’re sitting at a meal for longer than 30 minutes, that’s too long. 30 minutes is kind of [15:59] our… [16:00] our go-to amount. Now if you’re at the table with your family, and everyone’s chatting that’s one thing, but for a kiddo to be actively eating for longer than 30 minutes – we need to look at that. If there’s any difficulty with growth. Are we growing too much? Not enough? Height, weight…those kind of pieces. When those are a concern, then we need to look at that a little bit more. And that can even be that we’re having to supplement a lot with milk or PediaSure. Those kind of things are not what a kid who is typically developing would need. You know, [16:31] oftentimes those are showing us that kiddos aren’t able to keep up by eating solid foods, so they’re supplementing those… [16:36] those things. If there’s developmental delays. So if they’re having difficulty manipulating the food and bringing it to their mouth or holding the utensil or the cup, then it’s time to have an assessment. If they get stuck on one milestone. So if you have a kiddo who’s really stuck on using a bottle, and you’ve been actively trying to wean them from the bottle, and they’re really attached to the bottle; or if they’re really stuck on puree’d foods, and you want to move to foods that require chewing and they just seem stuck. Then…[17:07] then that’s time to move forward. If they’re coughing, choking, gagging, any of those things, we want to look at that a little bit closer. If you’ve been trying to get them to accept a spoon for a long period of time, you know [17:19] a couple weeks longer than that, and they’re stuck, and they’re not accepting it then it’s time to kind of [17:25] look and see what’s going on with that. If they’re completely refusing an entire food group. You know [17:31] kids don’t always prefer vegetables or they might not always prefer meat, but there’s usually 2 or 3 within that food group that they’ll accept. So if they’re like, “Absolutely not. I’m not eating those.” Then it’s…[17:42] it’s time to look at that. The other is: if mealtimes are just overly unpleasant. So when you go to have mealtime you’re super stressed, the kiddo seems super stressed, you…it…[17:54] there’s all this build-up around like, “Oh my gosh, there’s a mealtime.” Anytime that’s happening we can take a look at it. You can have an assessment from a team, and…[18:02] and really get some suggestions on how could you make mealtimes more enjoyable.

MD: Who are the people that are on a Feeding Team and what…[18:11] what providers should families be seeking out when they’re looking for a Feeding Team?

CM: It’s important to know that a Feeding Team can look different across different environments. So in an outpatient space, providers might see family one at a time. In a more clinic-driven space like we are here at the CED, we might see the family in a big group. So it might look a little different, but the team approach is what we know from evidence and science works, and what is best practice. The first person on a Team is the family. The family is super important; they should always be involved throughout the entire process. And I always see them as that first expert for the kiddo that we’re assessing. The other is a medical provider; so [18:53] we want to make sure that we have medical clearance, or any guidance we may need for that physician. For example, if a kiddo has a heart condition, they might be on a special diet. Or if a kiddo has a metabolic difference that we really need to make sure we’re really following and supporting that. So family, medical provider, and then in addition to that a dietitian who understands children with complex or special health care needs is really important, because different diagnoses can impact nutrition needs; so if they’re…[19:27] have a diagnosis of cerebral palsy or they have a diagnosis of high tone or low tone, the dietitian gives us information and helps guide our practice when we’re selecting what foods to add and things like that. An occupational therapist is important to work on all those fine motor eating skills, physical eating skills, sensory assessments. A speech/language pathologist, like myself, to look at oral motor feeding skills. We even look at language and things like that as we’re working through a feeding assessment to make sure that that kiddo is able to express needs and wants as we move through. A psychologist is also important on the team. They can look at the…[20:04] the dynamics of a family. They can also look and assess if a child is having increased anxiety around mealtimes. If they’re feeling depressed around mealtimes, it’s important to have that piece – a mental health specialist who’s able to look specifically at that dynamic. Also our Team has a social worker to look at food access and to talk about services that the family might be eligible for. And a physical therapist is also part of a Team – oftentimes to look at core stability and seating to support feeding.

CR: I think we touched on tips or tricks that parents can try at home a little bit, but is there any other tip or trick that you want to elaborate on or…[20:47] or offer for the listeners?

CM: I think the biggest one is that small exposures, um [20:52], are successes. Any time a kid engages with the food in a new way – huge success. So really capitalize on that by giving them a reward. Again, we talked about bubbles, stickers, clapping, high fives, whatever that looks like. But really recognize that your kiddo is working hard to make that success or that new attempt with food. So that’s a big one. Sometimes a lot of liquid in a diet can replace food. So we often recommend that families do solid food and then milk or PediaSure, however that’s been recommended. And over time we can work on fading that out and increasing the amount of solid food. The other one: those family meals are big, because if you are in a situation where kiddos are kind of separate from everyone else, they’re not getting those exposures to food; they’re just eating the foods that they like versus being at the table – they’re seeing it, they’re smelling it – like we talked about before, those gradual exposures of, “Oh, maybe I will touch that food” or “Maybe I will smell that food.” So I think those family exposures are big. The other one is – and it’s interesting because sometimes we’ll have families and we’ll ask you know [21:59], “What’s a typical meal look like in your family?” And they’ll share what that looks like. And then we’ll ask them what they would like to see their kiddo eating, and it’s not the same. So kids are typically going to eat what they see in their environment. Eating the kind of foods that you’d like your kiddo to eat is important. I you have other picky eaters in the household, sometimes that can kind of [22:18] bleed over into that kind of [22:21] same pattern for kiddos in the household too.

MD: And, Cassie, I think you touched on this a little bit, but does a child’s diagnosis play a role in feeding challenges?

CM: Yea, so [22:34] we do see some diagnoses where children are more likely to experience picky or selective eating. So…[22:40] kiddos on the Autism Spectrum Disorder, kiddos who have sensory processing differences, kids who have had severe reflux, global developmental delay, or kids who are transitioning to oral feeds from tube feeds; we often see that picky or selective eating occur more in those populations of kids. So [23:00] it can impact their eating. On the flip side of that, a lot of the kids we see have absolutely no diagnoses. You know [23:09] they’ve gotten into a routine of certain foods, and they’re having difficulty expanding; and it’s only eating. It’s just that one piece that they’re having a hard time with.

CR: You mentioned evidence-based practices. So what is the science behind the treatment?

CM: Sure. So [23:26] the first thing is a team. Um [23:28] evidence-based says we should use a team approach, because we talked about earlier that feeding challenges – selective/picky eating – can have lots of reasons. Right? [23:40] We talked about…it could be medical, or social – we always think about those things – it could be sensory, it could be development or those oral motor skills that it takes to eat, or it could be behavior. I don’t know every piece to all of those things, so I need to make sure that I have a team around me who can look really closely at all of those things. And that’s what our literature or science tells us about eating. The other thing is to treat feeding with feeding, you know [24:09] when you ask, “What does feeding therapy look like? What does assessment for feeding entail?” It should be that you see the kid eating, you engage with the kid eating, you know, [24:20] we really want to make sure that feeding’s happening during that assessment and during that treatment. Gradual exposures – we talked about that a little bit earlier – starting small and working up big, a structured approach with data. So even though what we’re doing often looks pretty fun: and families are engaging and we’re playing and we’re doing all those things, we’re really making sure that we are taking data so we know which way to direct treatment. Recognizing those small successes and reinforcing those is a big part of science. We know when we do something well and we get an “Atta boy!” or a “Great job!” then we want to keep doing it more. The other thing is monitoring and controlling responses from all the family members involved, and the babysitters, and the preschool teachers, so we make sure that we’re all doing the same thing, that we’re being consistent, and that we’re reinforcing what we’re doing the same way. Science tells us too that social exposures are really important and a great way for kids to learn, so that might look like: preschool - everyone’s eating the same snack, or family meals, even reading books about mealtimes and people sharing kind of [25:22] the same foods, or that foods are safe and they’re okay. So [25:25] Any of those social exposures. The other is that we get additional support from other sources and other professionals when we need it. So [25:33] if we think we could have an allergy, or if we think we could have a respiratory difference, we’re going to pull in those specialties as we need them instead of taking the “work through it” approach. I want to make sure that that kiddo’s foundational medical needs are being met. The other is parent support and education. We know that works. Parents want to know what’s going on with their kiddo. We want to make sure that they’re able to watch and learn and get support.

CR: So [26:01] how can the family take what they’re learning from the team and support that intervention during sessions of feeding at home?

CM: So [26:09] the first thing is: Kudos to a family for seeking out some assistance and some support for eating, because I think as caregivers or as parents, that first job we have is to make sure our kiddos are eating. Sometimes it’s hard to take that first step to say, “Wait a minute. This fundamental job that I see, you know [26:27] it’s hard for us. We need to work on it.” So…that. I think being supportive and consistent are the biggest things that families can do. So making sure that they are coming to sessions, that if the session is structured so that families aren’t invited, that a family might kind of [26:43] push a little bit and say, “No, I want to be in the session; I want to see what you’re doing so that I can you know [26:49] follow those same things at home.” And I think the other one is to really take information from the therapist or the clinician, so that you’re not giving foods to your kiddo that are too hard for them to manage. You know [27:02] if they’re working on oral motor skills, to make sure you’re giving them foods to really match where their skills are. And to also recognize how you respond when a kiddo does…[27:12] if they gag, if they cry, if they try to get up from the table. To make sure that there’s a plan for that so everyone’s responding in the same way; it’s not hurting your kiddo, but it’s just really doing things in a consistent way so we’re all on the same team.

CR: What is your one piece of advice that you would give to parents who have concerns about their child’s feeding?

CM: I think understanding that there’s help out there. And even if a physician has shared that they’re not super concerned, families usually have a gut reaction when something’s hard for their kiddos. And uh [27:52] sometimes physicians are just looking at things like weight or checking off, you know, [27:56] skill development, and they just don’t recognize everything that a family’s putting in around mealtimes to make those things happen. And not all physicians have experience with feeding challenges. So just asking for an assessment, recognizing that there’s help out there, and you know [28:11] I think there’s the additive that “kids will grow out of it”, you, you know [28:14] “they’ll eat what they’re given”, “they’ll eat when they’re hungry.”

That’s not necessarily true. And so just going with your gut and…[28:20] and asking for help, and asking for an assessment. There might be 2 or 3 things that you pick up from that assessment that really can change mealtime in your home.

MD: Cassie, what if a child requires intervention due to eating concerns, but they live in a rural part of the state; and it’s difficult for them to get to Morgantown or Marshall? What are…[28:42] what are their options?

CM: So for us, what we try to do if possible, is to coordinate with the family when they might be coming up for another appointment to Morgantown, so we can see them one time in person; and then after that we do Telehealth. And Telehealth works really well, because the parent – they’re really the ones who are going to do the intervention, and so Telehealth works really well for us. And the way we have it set up is: we just email a link, family clicks the link, we’re all on. So it just requires internet access, and even if the family doesn’t have a computer or a device that they can use, we can even rent one of those to them for the duration of their treatment so they’re able to get access to that. We even have relationships with DHHR offices or libraries, where families can go in if they want to use the internet; and there’s spaces if they don’t have it at their house. So traveling to Morgantown – ideally, we do it at least once, and then after that we can do Telehealth.

MD: Cassie, how would the assessment be covered? Do families have to pay for it out of pocket or does insurance cover that?

CM: Yea, so [29:48] again that’s one that’s facility-dependent, but insurance covers assessment. So if you have coverage for therapy or outpatient services, then that would be covered by insurance. For us, we’re a ‘no fee for service.’ So when families come here to see our team, we don’t have to bill insurance or anything like that. But that assessment is covered by most insurances, it’s covered by most state insurances, and then some facilities – like ours, because we’re here at the CED – there’s no fee for service.

CR: This is excellent information, Cassie. Thank you. Feeding questions are not exclusively the concerns of parents of children with disabilities. 60% of kids will at minimum have bouts of picky eating. We’ve linked some resources in the show notes that Cassie suggested we pass along to listeners, and personally, I found the material extremely helpful. Information regarding the WVU and Marshall Feeding Clinics will also be provided and ways you can get in contact for additional questions or to schedule an evaluation for your child. I hope this topic has been informative, and I appreciate you tuning in. Thanks for all you do. We’ll see you next time.

MD: This podcast is sponsored by the Children with Special Health Care Needs Program through the Office of Maternal, Child, and Family Health with the Department of Health and Human Resources and produced by Center for Excellence in Disabilities at West Virginia University.