SNACKids©

Sally Asquith, MS, CCC-SLP, and Amanda Morse, MS, CCC-SLP

Carolina Speech & Language Center, Inc., Summerville, SC

SNACKids©

Social Nourishment, Advancing Competence in Kids

Background: Carolina Speech & Language Center is a pediatric private practice near Charleston, SC, specializing in autism, multiple disabilities, social groups, and dysphagia. Patients range from infants to young adults. Group therapy proved highly successful for social skills/pragmatics; in 2007 we began snack groups. Initial trials were rewarding – and then thoroughly revolutionized our therapy, underscoring the concept of why we eat, beyond basic nutrition: it is fundamentally a social activity.

We designated a 7x9 space for "snack room", then expanded to 9x14, and finally took over the staff kitchen (14x14).

Outcome: *The snack room has become the hub of the clinic, with remarkable success with dysphagia patients.*

Hypothesis: Is pediatric dysphagia therapy more effective in an incidental, peer-rich environment group than in an individual, adult:child setting? There is a paucity of research in this area. Most research focuses on various behavioral interventions (e.g. Ledford & Gast). To date, a literature search has rendered no results in this particular area.

We conducted a retrospective chart review of all current patients (*n* 170) and those receiving dysphagia tx (*n* 59, or 35%) as the basis for measuring achievement.

We also codified the methodology of incidental, naturalistic, peer-rich therapy in a designated space.

OBJECTIVES

1. Blend systematic desensitization with visual supports, open choices, objective comments, and careful use of attentional focus…
2. Offer peer encounters of all ages, largely incidental, sometimes legislated…
3. Present meals/snacks as a social, community event on a chronic, predictable basis…. ***IN ORDER TO…***
4. Improve ~~

- acceptance of food as a non-threatening object
- volume and variety of intake
- bolus direction
- "power" in orofacial musculature
- requisite oral-motor skills for age-appropriate textures
- drinking skills

PROTOCOL AND METHODS

- Designated space ideally with walls, open shelves, closed cabinets, and clearly separated by a door that closes.
- Equipped with refrigerator, m/w, toaster oven, toddler seat, and high chair; plus a low, sturdy table and chairs for six children and a drop-leaf table for two adults or teens.
- Photos of various foods form a border near the ceiling.
- Clearly visible large dry erase "Food is Good" board lists the vocabulary for describing bolus size (and to-scale drawings), texture, temperature, and flavor.
    - "Size" ranges from a dot ("crumb") to 1¼" ("huge bite")
- Systematic desensitization approach uses "support-not-force" (Dunn Klein) and SOS (Toomey) principles.
- Tx begins at the child's tolerance/perceived safety level for:
    - DE = diet expansion
    - TLJ = tongue-lip-jaw dissociation
    - BMS = bolus management/direction, and/or safety
    - CHEW = chewing
    - LAT = lateralization
    - D = drinking
    - V = volume
    - NPO = currently NPO, transitioning
- ***Incidental, spontaneous interactions*** with peers and adults, with food as the lingua franca
    - This completely natural aspect is CRITICAL in creating a relaxed, no-pressure environment
    - The focus automatically shifts from a perception of demand + power to a perception of social sharing
    - Fear, apprehension, and vigilance decrease
- Adult language:
    - Bona fide questions only
    - Neutral, factual comments ("This apple is crunchy")
    - Clear, unambiguous instructions ("Sit, please")
    - Modeling and teaching descriptive vocabulary based on the "Food is Good" chart
- Individual dry erase boards as visual schedules

RESULTS

- Current total caseload = 170
- Current dysphagia caseload = 59 (35% of total pop)
- Pts (*n* 59) referred specifically for feeding tx = 33% (*n* 20)
- **Pts recruited by asking (*n* 39) = 67%**

- **Classifying by # of ARFID helped define our population**
    - 56% (*n* 33) of dysphagia pop had ARFID at SOC
        - ARFID 5 = 1
        - ARFID 10 = 9
        - ARFID 15 = 0
        - ARFID 20 = 18
        - ARFID 30 = 5
- **Progress across all pts = 100%**
    - All pts demonstrated significant progress, regardless of dx, hx, age, gender, or goal type
    - The ARFID 5 pt is now 30+ and swallows small boli
- **What we OBSERVED but did not classify or measure:**
    - Happiness with friends
    - Degree of relaxation around food
    - Reduced stress levels in pts and parents
    - More neutral affect, more SMILES ☺

ARFID 20 (hx of hypertrophic adenoids) and ARFID 5 (hx of severe choking episode), trying yogurt together

CONCLUSIONS and LIMITATIONS

1. A peer-rich, casual environment supports pediatric dysphagia tx.
2. Simply asking families "How is his/her diet?" recruits 200% more pts and reveals occult dysphagia. This finding implicates SLPs, OTs, and particularly pediatricians to ask the question as SOP.
3. Specifying the # of foods in ARFID pts offers the specificity we need in setting metrics and acknowledging different (i.e. more vs. less serious) levels of ARFID.

We did not code pts by therapeutic goals. Each pt has a customized tx plan that confounded tracking. In the future, we will create a streamlined goal bank to follow achievement by specific goal type (e.g. texture advancement vs. tongue-lip-jaw dissociation).

The future: physical parameters to monitor stress, such as cortisol levels, heart rate, respiration?

REFERENCES

Beckman D. *Beckman Oral Motor Assessment and Intervention*. 1986, revised 2007. Published by Beckman & Associates, Inc., 1211 Palmetto Ave., Winter Park, FL 32789.

Dunn-Klein M. Anxious Eaters Anxious Mealtimes. Mealtime Notions. http://static1.squarespace.com/static/55c8cf07e4b0d5f0a7213aa3/t/55ccd8f2e4b01e36b69860df/1439488242935/Anxious-Eaters-Anxious-Mealtimes1+%281%29.pdf Accessed 9/16/2016.

Fraker C, Fishbein M, Cox S, & Walbert L. *Food Chaining*. 2009. Boston, MA: Da Capo Press.

Ledford J & Gast J. (2006). Feeding Problems in Children with Autism Spectrum Disorders: A Review. *Focus on Autism and Other Developmental Disabilities, 21,* 153-166.

Toomey K, Ross, E. SOS Approach to Feeding. SIG 13 Perspectives on Swallowing and Swallowing Disorders (Dysphagia), October 2011, Vol. 20, 82-87. doi:10.1044/sasd20.3.82

ACKNOWLEDGEMENT

Deepest gratitude to the many families who have entrusted us with their children's health, happiness, and well-being.

CONTACT

Sally Asquith: s.asquith@mycsal.com 843.832.1795

Amanda Morse: a.morse@mycsal.com 843.832.1795