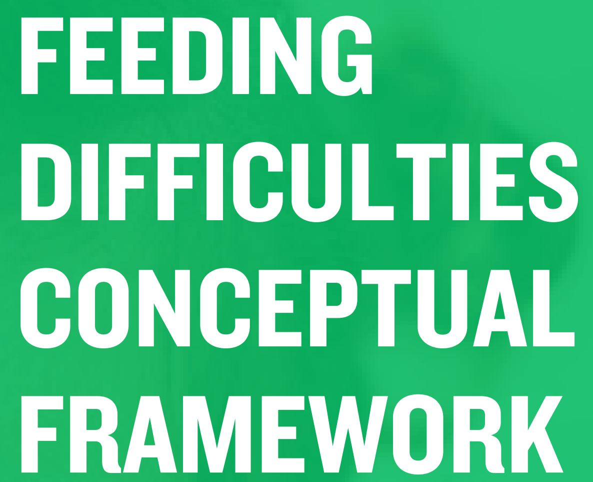

FEEDING DIFFICULTIES CONCEPTUAL FRAMEWORK

Case study

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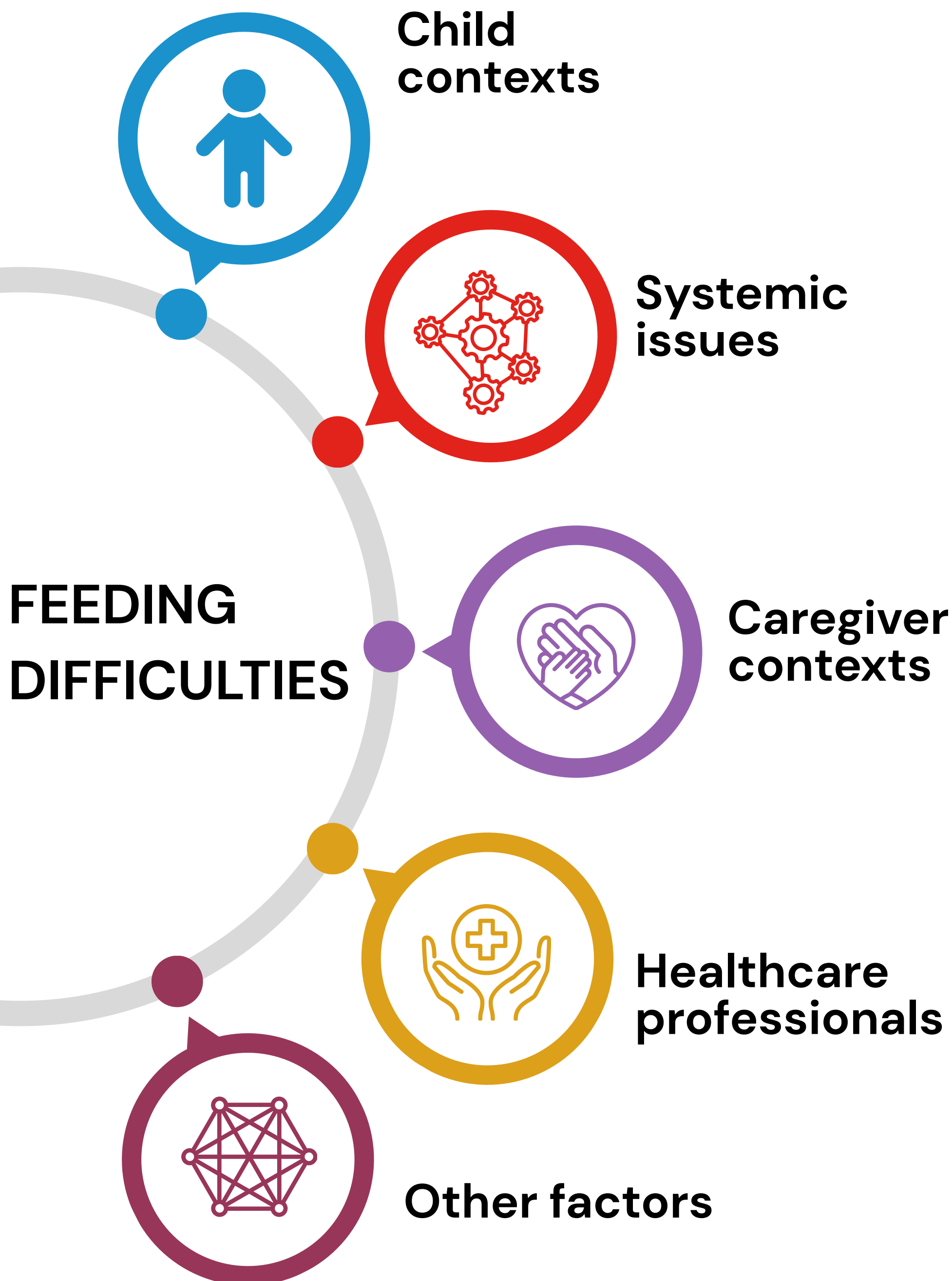
The framework

The framework provides a structure for multidisciplinary collaboration, supporting individualised, context-sensitive, family-centred, and inclusive care. In this way, supports are responsive to the diverse realities of families, whether shaped by cultural diversity, geographic location, or systemic barriers.



The following case study will guide you through how to practically apply the conceptual framework to support families in managing feeding difficulties.

Meet Milo

Milo is a 14-month-old boy, referred for persistent feeding difficulties including:

- refusal of textured foods, and
- inadequate weight gain.

Milo lives with his parents, who emigrated from a non-English speaking country one year ago. The feeding challenges persist despite repeated advice from various healthcare professionals.

Child context

Examples: Medical complexities, co-occurring conditions, feeding skills, temperament.

Milo displays aversion to certain textures and requires prolonged mealtime durations. Developmental screening indicates otherwise typical milestones, with no major neurological or anatomical abnormalities. Observations reveal that Milo is easily distracted, becomes distressed with spoon feeding, but shows interest in self-feeding with finger foods. Sensory sensitivities may underlie his feeding behaviour.

Sytemic issues

Examples: Remote geographic locations, poor availability of staff, increased waitlists, poor post-partum care.

The family's recent immigration status results in unfamiliarity with the local healthcare system, making it difficult to access consistent, culturally-sensitive care. Health and community services lack interpreters or multilingual resources. Appointments are fragmented, and Milo's case is managed by multiple providers with little communication between them, perpetuating confusion about next steps.

Caregiver context

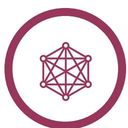
Examples: Work-life balance, caregiver picky eating, caregiver anxiety.

Milo's mother is the primary caregiver and reports high levels of stress due to her perceived inability to provide proper nutrition. She expresses frustration and guilt, influenced by memories of traditional feeding practices from her home country. Language barriers limit her engagement with support groups and local resources. The family's social network is limited, intensifying feelings of isolation.

Healthcare Professional context

Examples: Healthcare professional knowledge, attitudes and practices.

Initial recommendations from healthcare providers focused on standard paediatric feeding guidelines, with limited consideration of the family's traditions or language needs. This created friction, as Milo's mother felt her concerns and cultural practices were dismissed. Some practitioners assumed non-compliance without probing barriers, leading to strained rapport. Upon reflection, providers recognised the need for more flexible, tailored plans and demonstrated openness to learn about cultural feeding norms.



Other factors

Examples: Societal, temporal, cultural and psychosocial factors.

Societal expectations for rapid child adaptation to "mainstream" eating patterns contrasted with Milo's family's gradual approach, causing additional pressure. Temporal issues included the stress and instability of recent migration. Cultural beliefs influenced what foods were offered, the importance placed on feeding routines, and comfort with certain intervention strategies. Psychosocial stressors such as isolation, homesickness, and loss of extended family support further amplified caregiver anxiety and child-mealtime tension.

Summary of challenge/observations

At the center of this multi-layered framework lies Milo's feeding difficulty, which cannot be fully addressed without integrating the surrounding contextual domains. Each framework element reveals specific challenges that, if unexamined, could undermine feeding interventions. By systematically addressing all domains:

- adapting recommendations to family culture,
- offering interpreter services,
- creating case conferencing between providers, and
- facilitating peer support

- the practitioner crafts an intervention plan that is respectful, effective, and truly family-centered.

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