RESPONSIVE PRACTICE AND SHARED CONTROL

A Clinical Reasoning Handout for Pediatric Feeding Professionals

Purpose

Responsive practice requires more than recognizing a child's preferences or following the child's lead. It requires us to understand the child within the context of their developmental capacities; medical, sensory and physiological experiences; history; relationships; and environment.

This handout explores how **relational autonomy, shared control, and responsive caregiving** can inform clinical reasoning when children resist expectations, avoid demands, or struggle to participate in mealtime routines.

The goal is not to identify one universally correct response. It is to help clinicians ask better questions, understand what may be influencing a child's response, and determine how to support meaningful change without losing sight of the child's experience or the adult's responsibility.

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1. Start with the child, not the behavior

A child's response is information. It is not, by itself, a complete explanation of what is happening or a prescription for what the adult should do next.

When a child refuses food, resists sitting at the table, leaves a mealtime activity, or becomes distressed when an expectation is introduced, we need to understand what may be contributing to that response.

Consider the possible influence of:

- Physiological, medical, or oral-motor difficulties.
- Sensory experiences and environmental demands.
- Developmental capacities, communication, and comprehension.
- Regulation, anxiety, uncertainty, and predictability.
- Previous feeding experiences and learned expectations.
- Relationships with caregivers and the history of adult responses.
- Family routines, cultural practices, resources, and available support.
- The purpose of the expectation and whether the chosen method is necessary.

Several factors may interact. Two children who exhibit similar behaviors may have very different experiences and need different support.

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> ***Clinical reflection**: Before deciding how to respond to a behavior, ask what the behavior may be communicating, what experiences may have shaped it, and what additional information you need.*

2. Autonomy is not the same as independence

Autonomy concerns agency and self-determination. Independence generally refers to functioning without assistance from another person.

These concepts overlap, but they are not interchangeable.

A child can exercise autonomy while depending on adults for care, support, co-regulation, and guidance. Children develop their capacity for self-determination over time, within relationships and social environments.

Self-Determination Theory identifies autonomy, competence, and relatedness as important psychological needs (Ryan & Deci, 2000, 2017). Relational autonomy further challenges the assumption that autonomy is best understood as independence from others. Dove et al. (2017) emphasize the ways relationships and social contexts influence agency and self-determination.

For clinical practice, this means that supporting autonomy is not simply a matter of giving children more choices or withdrawing adult involvement.

It includes considering how adults respond to children's communication, how they make room for preferences and participation, how they provide appropriate support, and whether children have meaningful opportunities to influence their experiences.

> ***Clinical reflection**: Am I supporting the child's developing agency, or am I assuming that autonomy means either doing everything independently or deciding everything for themselves?*

3. Shared control: holding child agency and adult responsibility together

Shared control is a way of thinking about the bidirectional relationship between a child's developing autonomy and the adult's ongoing responsibilities. It is not a 50/50 division of control. It is not a rule that the child determines every aspect of an interaction. It is not a strategy for obtaining compliance through the appearance of choice.

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The child influences the interaction through communication, preferences, responses, capacities, and participation. The adult influences the interaction through decisions, expectations, environmental arrangements, and responses to the child.

Both matter.

The adult remains responsible for providing care, considering safety, establishing appropriate structure, and making decisions that fall within the adult's role. At the same time, the adult must take the child's experience seriously and consider how their actions support or constrain the child's developing agency.

Shared control asks us to hold these responsibilities together rather than treating them as opposing positions.

In practice, this may mean:

- Maintaining an appropriate goal while changing the method.
- Providing structure while adapting its implementation.
- Offering meaningful choices without making every expectation negotiable.
- Recognizing distress without assuming that every expectation must immediately disappear.
- Building capacity without making compliance the measure of progress.
- Accommodating a child's needs without assuming that accommodation is failure.
- Reconsidering a goal or pausing intervention when the goal, timing, or approach is not appropriate.

> ***Clinical reflection****: How can I remain responsible for the plan while making meaningful room for the child's experience, communication, and developing agency?*

4. Responsive does not mean permissive

Responsiveness involves noticing, interpreting, and responding to a child's experience. It includes flexibility, curiosity, and willingness to adjust an approach when new information emerges.

Responsiveness does not require the absence of expectations, structure, boundaries, or adult guidance.

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The important questions are:

- Is the expectation appropriate and meaningful?
- Does the child have the capacity and support needed to participate?
- Is the method necessary, or is it simply familiar?
- How is the expectation being experienced by this particular child?
- What does the child's response tell us about the current approach?
- Are we willing to modify the plan when our understanding changes?

A child may need support to develop a skill or participate in a routine. The adult can provide that support while remaining responsive to the child's experience.

Conversely, removing every expectation is not necessarily responsive if it leaves an important need unaddressed or prevents the child from accessing meaningful support.

> ***The goal*** *is not to choose between adult direction and child autonomy. The goal is to determine what the child needs and how the adult can respond appropriately.*

5. Understand what the child has learned to expect

A child's response to a current expectation may be influenced by previous experiences.

For example, sitting in a highchair may have repeatedly preceded pressure to eat, unwanted physical assistance, distressing feeding experiences, or interactions in which the child's communication did not change what happened next.

The chair may no longer be a neutral part of the environment. It may predict an experience the child has learned to resist.

In this situation, changing the chair, shortening the meal, or using gentler language may not be sufficient on its own. We also need to consider what the child has learned to anticipate.

The child may need repeated experiences in which:

- The adult notices and responds meaningfully to communication.
- The environment and interaction are more manageable.
- The child's participation does not automatically lead to the previously distressing experience.
- The adult's response is not predetermined regardless of the child's cues.
- The child has opportunities to experience greater predictability, agency, and safety.

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Sometimes, the first meaningful change is not getting the child to participate in the original routine. It is changing what that routine has come to predict.

This may require a period of changing or separating the current experience from previously learned negative associations. Here, “disassociation” from previous negative mealtime associations refers to creating different experiences and expectations; it does not refer to dissociation as a psychological symptom.

This is not a reason to assume that every child who resists a demand has experienced trauma. It is a reason to take the child's history seriously rather than treating current behavior as if it arose in isolation.

> ***Clinical reflection**: What might this child have learned to expect? What would need to be different for the experience to become more manageable or meaningful?*

6. Distinguish the goal from the method

A common clinical error is to identify a potentially meaningful goal and then assume that the preferred method of achieving it is essential.

Consider a child who does not sit at the table.

Possible goals might include:

- Safe and stable positioning.
- Access to food.
- Participation in family meals.
- Development of a predictable mealtime routine.
- Opportunities for social connection.
- Increased comfort within the mealtime environment.

Sitting in a conventional chair for a predetermined duration is one possible method of supporting some of these goals. It is not automatically the only appropriate method.

Before deciding how to address the child's resistance, clarify what the goal is intended to accomplish.

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Ask whether the current method is necessary, whether accommodations are indicated, and whether the child's history makes the proposed starting point inappropriate.

The goal may remain meaningful even when the initial approach needs to change.

> ***Clinical reflection**: If I changed the method, would the meaningful goal still be achievable? If not, why is this particular method necessary?*

7. Structure and individualization belong together

Supportive mealtime structure can help families establish predictable routines and organize when, where, and how meals and snacks occur. Practical guidance can be valuable, particularly when families need concrete information about food offerings, scheduling, and mealtime language.

Ellyn Satter's Division of Responsibility in Feeding (Lohse & Mitchell, 2021; Satter, 1995, 2014) is an important underpinning of this approach. In my work, the Merry Mealtime™ Guide translates principles of supportive mealtime structure into practical guidance for therapists to use within a parent-coaching model. The Guide is a clinical resource incorporated into ***AEIOU: An Integrated Approach to Pediatric Feeding***, where we explore its application as part of a broader, individualized approach to responsive feeding therapy.

The Merry Mealtime™ Guide includes concrete recommendations, such as sitting at a table, meal and snack durations, and considerations about what and how much food to offer. These recommendations are intended to support families, not to replace clinical reasoning or individualization.

The accompanying Practitioner Manual emphasizes the importance of understanding each family's cultural context, experiences, goals, resources, and support systems, as well as the child's medical, developmental, and feeding history.

Therapists do not simply hand the Guide to parents and expect them to implement it. They coach families in determining how to begin making meaningful changes, which changes are feasible, what accommodations may be needed, and how to adapt implementation to the child and family.

For one family, establishing a predictable routine and helping a child sit at the table may be an appropriate starting point. For another, a history of distressing feeding experiences may mean that sitting in the chair is not yet an appropriate expectation.

Individualization does not mean abandoning structure. It means considering how structure can be implemented in a way that supports the child and is meaningful and sustainable for the family.

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> ***Clinical reflection**: Am I using a guide as a source of principles and practical support, or treating it as a universal protocol that every family must follow in the same way?*

*About the **Merry Mealtime™ Guide**: The Guide and accompanying Practitioner Manual are course resources provided to participants in **AEIOU**. They are not included with this free handout. Their mention here is intended to introduce the clinical principles and parent-coaching approach that inform their use.*

8. Accommodation, capacity-building, or pause?

Once we understand the likely contributors to a child's difficulty and clarify the purpose of the goal, we can consider the most appropriate next step.

Accommodation
Modify the environment, routine, expectations, or method to address a barrier or support access. Accommodation may be an appropriate ongoing support. It does not need to be viewed as a temporary step toward removing the accommodation.

Capacity-building
Provide appropriate opportunities, teaching, support, and practice to help the child develop skills or participate in an experience. Capacity-building is not synonymous with teaching compliance. It should take account of the child's current abilities, communication, experience, and response.

Pause, protect, or recover
Pause or reconsider the proposed goal or method when the child is experiencing significant distress, when the purpose of the expectation is unclear, or when the available information suggests that the current approach is not appropriate.

This may include changing the conditions of the interaction before asking the child to participate in the original routine.

These responses can be combined. A child may need accommodation while developing a skill, or a family may need to change a routine while the therapist gathers more information.

The question is not which response is universally correct. It is which response fits the child, the context, and the purpose of the intervention.

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9. A clinical reasoning example: the child who will not sit at the table

A child consistently resists sitting at the table for meals.

Rather than immediately implementing a plan to increase sitting, work through the following questions.

Clarify the goal. What is sitting intended to accomplish? Is the goal positioning, safety, access to food, family participation, or something else?

Understand the child. What happens when sitting is suggested? What does the child communicate? Are there physical, sensory, developmental, emotional, or relational factors that may contribute?

Explore the history. Has the child experienced pressure, discomfort, distress, or unwanted interactions during meals? What might the child have learned to anticipate?

Examine the environment and expectations. Is the seating appropriate? Is the routine manageable? Is the duration necessary? Is the family able to implement the proposed changes within its circumstances?

Consider shared control. How can the adult maintain responsibility for supporting the family while responding meaningfully to the child's experience?

Choose the next step. Would an accommodation, a change in the interaction, capacity-building, or a pause be most appropriate? Does the goal need to be sequenced differently?

Evaluate more than visible compliance. Is the child experiencing the environment differently? Is communication being recognized? Are the changes feasible for the family? Is the plan supporting meaningful participation and well-being?

The aim is not to win a struggle over the chair. It is to understand the child and determine how best to support the child and family.

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10. Reflective questions for clinical practice

Use these questions during assessment, intervention planning, parent coaching, and reflection on treatment outcomes.

1. What do I know about this child's medical, developmental, sensory, and feeding history? What do I still need to understand?

2. What might the child's response be communicating, and what alternative explanations should I consider?

3. What has the child learned to expect from this situation and from the adults involved?

4. Is the goal meaningful and necessary? Is the chosen method essential?

5. How does the current approach account for the child's autonomy and the adult's responsibility?

6. What role do the family's culture, priorities, resources, routines, and support systems play in determining the plan?

7. Would accommodation, capacity-building, or a pause be most appropriate at this point?

8. Am I evaluating the child's experience and the quality of participation, or primarily whether the child performed the requested behavior?

9. What would need to change for the child to experience this situation differently?

10. How will I know whether the approach is supporting meaningful progress for the child and family?

A final reminder

Responsive practice is not the absence of adult responsibility. Shared control is not unrestricted child choice. Structure is not inherently coercive, and accommodation is not inherently permissive.

The task is to understand the child, the family, the history, the context, and the purpose of the expectation, and then determine how to proceed.

We do not need to choose between respecting a child's autonomy and recognizing our responsibility as adults. We need to learn how to honor both.

That requires more than a strategy. It requires clinical reasoning.

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About This Resource

The concepts explored in this handout reflect a broader philosophy of pediatric feeding therapy developed through more than 32 years of clinical experience and nearly two decades of teaching pediatric feeding professionals through ***AEIOU: An Integrated Approach to Pediatric Feeding***.

Throughout my clinical practice and teaching, I have continued to explore what it means to provide effective, individualized, and responsive feeding therapy. This includes recognizing that clinical expertise is not simply knowing which strategy to use but understanding why a particular approach may or may not be appropriate for a particular child and family.

The Merry Mealtime™ Guide and accompanying *Practitioner Manual* mentioned are among the resources incorporated into ***AEIOU***, where their application is explored within a broader framework of responsive, relationship-based feeding therapy.

The principles presented here are offered as a standalone resource for professional reflection and clinical application. You do not need to have taken ***AEIOU*** to use or benefit from the information in this handout.

Clinicians interested in exploring this approach in greater depth can learn more about ***AEIOU*** at **www.foodsmartkids.com**.

About the Author

Nina Ayd Johanson, MA, MS, CCC-SLP, CLC, is a speech-language pathologist, pediatric feeding specialist, and founder of Food Smart Kids, LLC, with more than 32 years of clinical experience.

Nina developed ***AEIOU: An Integrated Approach to Pediatric Feeding*** in 2008 and has continued to teach and refine this comprehensive professional training program since its inception. Through ***AEIOU***, she has trained thousands of therapists throughout the United States and internationally, sharing a framework for pediatric feeding that extends well beyond a collection of strategies. Grounded in responsive feeding, it emphasizes integrated clinical reasoning that prioritizes child autonomy and relational safety and recognizes the influence and importance of family relationships. It challenges professionals to think holistically as they develop individualized, family-centered, and compassionate approaches to intervention.

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Note: This handout is intended to support clinical reflection and reasoning. It is not a diagnostic tool or a substitute for individualized assessment.

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