Changing The Conversation:

From "Getting Kids Thin" to Promoting Nurturing Eating for *ALL* Children

By Elizabeth Jackson MS, RD

As carefully argued by Dr. Robison, recent proclamations and policy directives about child obesity are, to a large extent, misinterpretations of the data about children who are naturally larger than average and oversimplifications about the etiology, prevention and treatment of childhood weight issues. There is no denying that many American children, whether genetically predisposed to be small, medium or large, have diverged from a normal growth trajectory.

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The problem with sounding a call to arms about these children is that we misdiagnose (in fact, pathologize) normally growing large children, very likely leading to the problems we are trying to avoid, i.e., escalating weight gain. Likewise, we miss out on early opportunities to work in primary intervention settings with children who are, indeed, showing abnormal growth divergence. Is there an alternative to a blanket categorization of risk for all children falling above (or below) standard BMI-for-age percentiles?

Trust vs. Control

There is, according to Ellyn Satter, a leading authority on child and adult feeding and eating problems. Ms. Satter is a mental health therapist and registered dietitian with 40 years of clinical experience. She has written many scholarly articles and four books on child feeding for professionals and parents, and she leads advanced training workshops for nutrition, health and mental health professionals.

The Satter Feeding Dynamics Approach (or fdSatter) hinges on a core concept of trust: trust that children come hardwired to have certain bodies and are born with strong internal regulators of eating—hunger (drive for fuel), appetite (drive for pleasure) and satiety (satisfaction, the natural stopping point when hunger and appetite are fulfilled). If these internal regulators are preserved with the help of nurturing feeding from caregivers, children can grow up to have the bodies that are right for them. The trust model contrasts with the traditional approach of adult caregivers working to control children's eating in order to ensure their "proper" size.[1]

Satter describes a new definition of child overweight as an upward weight divergence that is abnormal for a given child and can be determined, therefore, only by comparing the child to him or herself over time.[1] This is accomplished via an accurately-kept growth chart, rather than an arbitrary BMI cutoff. Likewise, underweight is defined as an abnormal downward divergence in a child's growth pattern. If a child does begin to grow abnormally, something is undermining his or her powerful inborn ability to regulate and the disrupting factors need to be uncovered and corrected to treat the abnormally diverging growth. Satter has crystallized this concept in a position stand on child overweight which appears following this article.[2]

The prevention and treatment of child overweight are therefore both guided by the same principles: preservation or restoration of internal regulation of eating for children. Satter believes parents can optimize child growth from birth with the trust model as implemented through her Division of Responsibility (DOR) in feeding.[3] According to DOR, parents are

responsible for some tasks in child feeding, children others, and families stay out of trouble if these lines are not crossed. Specifically, parents take leadership in choosing foods, preparing (or facilitating) meals and planned snacks at structured times, and keeping eating times pleasant and companionable. This means sitting down, eating and conversing with their children, rather than just feeding them. It also means that they trust their children and give autonomy for them to enact their part of the DOR. Children are responsible for choosing from the foods provided and eating as much or as little as they want of each (sometimes varying wildly in type and amount from day to day!) without parents needing to coax, bribe, threaten or restrict certain foods. It is within this context of non-pressured structure and emotionally gratifying time with adults that children are able to heed hunger, appetite and satiety signals and become competent eaters.

What about food selection goals? More milk, vegetables and fruits? Less soda? These are all best accomplished within the context of the family meal. When children are raised with DOR, they will eat the amount they need to grow according to their genetic blueprint, learn to eat a variety of foods, acquire all the socialization implicit in communal meals (hinging on regular access to their parents), feel good about their bodies and gain food procurement and preparation skills to become independent with feeding themselves by the time they leave home.[4] Implicit in this model is that not all children will be slim. Therefore, we need to help children feel positive about the notion that bodies come in all sizes. This is how we can help children of all sizes to be healthy.[5, 6, 7]

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An Evidence-Based Approach

Satter's approach is evidence-based and ties together work from diverse fields, from the premise that size is largely determined genetically[8] to the efficacy of authoritative parenting styles[9] to the advocacy of family meals as a framework for everything from better nutritional intake[10, 11, 12] to better emotional health,[13] lower incidence of adolescent risky behaviors,[14, 15] including eating disorders,[16] and yes, even to weight regulation.[17, 18] Furthermore, in the context of feeding, strategies and parenting styles that contradict DOR have been shown to undermine a child's ability to regulate and can lead to childhood growth and weight problems. Researchers have found that overcontrolling or undersupportive parental feeding practices (restriction, pushy feeding, lack of structure, lack of limits) are counterproductive, whether with healthy children[19-22] or those with a chronic illness.[23, 24] Parents with their own significant eating, weight and body image struggles often engender these problems in their children and create higher risk for both abnormal weight divergence and eating problems or eating disorders.[25-29]

The phenomenon of disinhibited eating following restricted eating was first described in the famous Minnesota experiment in semi-starvation over half a century ago[30] and in deliberately restricting (dieting or restrained eating) adults over

thirty years ago.[31] In the mid-1980s, Costanzo and Woody[32] proposed a model whereby concerned parents trying to slim their children would create the very problem they were attempting to avoid by interfering with children's ability to learn to self-regulate, creating "eating-guilty" children. These children would feel shame and anxiety about eating, yet would have "brittle restraint" and would be easily induced to eat by environmental cues or emotions. Sure enough, whether at their own initiation or following advice from a health professional, parents who diet and then disinhibit[33] or who restrict their child's food because of concern over a child's weight or size often precipitate disinhibited eating in children[34] which can lead to weight acceleration.[35] In fact, a recent review linked parental feeding restriction as the key behavior facilitating development of overweight in children.[36] In this way, the iatrogenic paradox is clear: restricting children backfires and can make them heavier. In addition, parents' negativity about a child's weight can lead to significant, lasting psychological damage.[37]

"Restricting children backfires and can make them heavier."

It is also important to remember that situations which mimic deliberate food restriction, such as food insecurity (living with hunger and the fear of starvation), lead to another paradox: some of the heaviest children (and adults) in America are the poorest. Indeed, many researchers blame the same mechanisms— cycles of food deprivation and binge-like eating when food is available.[38, 39, 40] In addition, research indicates that children with the most profound growth aberrations—extreme obesity and growth failure—often have profoundly troubled lives[41-44] and growth problems can thereby serve as an important red flags.

Clearly, these are extremely complex issues. Satter's paradigm takes abnormal weight divergence very seriously. In the behavioral realm of how we feed our kids, day in and day out, we do now have clear, evidence-based answers. Instead of obesity prevention or treatment programs that attempt to reduce weight by controlling children's eating, we need interventions that help children maintain their internal regulation signals and at the same time help adults provide positive feeding and eating experiences for children of all sizes. As Satter says, we must provide, not deprive. ★

▸ To view the source references for this article, please turn to the section, *Redefining Childhood "Overweight," Rethinking "Healthy" Eating* on page 32.

About Elizabeth Jackson, MS, RD

Elizabeth Jackson, MS, RD has used internal regulation of eating as the cornerstone of her work in dietetics for 20 years, after having embraced Ellyn Satter's teachings as a dietetics student in Wisconsin. In 2002, she was invited by Satter to be one of the founding members of the Ellyn Satter Institute (ESI), which is currently creating a not-for-profit foundation devoted to consulting, teaching and research. Now in her 17th year of private practice in Mt. Pleasant, Michigan, Elizabeth works as an eating and nutrition consultant for most outpatient diagnoses, specializing in child feeding, eating and growth problems and clinical eating disorders. As a part-time faculty member at Central Michigan University, she also teaches a popular upper level course she created on eating disorders for dietetics and other allied health majors, currently offered online, as well, through CMU's graduate program in dietetics. Through ESI and her consulting business, she provides presentations and workshops for health professionals and educators throughout Michigan, the U.S. and Canada. Elizabeth believes that it is only through the preservation of and return to internal regulation of eating that child and adult weight dysregulation and eating disorders can be successfully prevented and treated. Elizabeth can be reached at: ***ejacksonrd@journey.com***. For more information on Ellyn Satter and her work, see www.ellynsatter.com.

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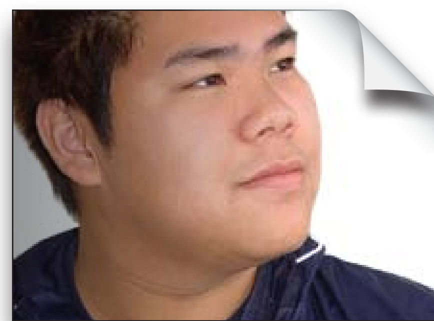
Position Statement:

Eating Management To Prevent And Treat Child Overweight



By Ellyn Satter, MS, RD, LCSW, BCD

THE POSITION OF THE ELLYN SATTER INSTITUTE is that the clinical definition of child overweight is not high weight *per se*, but *growth acceleration*: abnormal upward weight divergence for the *individual* child. Based on this clinical definition, each child is compared to only him- or herself, not to statistical cutoff points established for the purpose of population-wide evaluation. This definition avoids labeling as overweight the child whose weight, weight-for-height or BMI are above a certain percentile but is growing consistently. It also allows identifying for early intervention the child whose measurements fall closer to the mean but is nonetheless diverging from his or her previously established growth pattern.

Defining child overweight as growth acceleration reframes prevention. Rather than *avoiding overweight*, the emphasis becomes *supporting each child's normal growth*. Thus, child overweight can be *prevented from birth* with appropriate feeding. Growth acceleration can be *treated* by examining the underpinnings and antecedents of the divergence, restoring positive feeding and letting the child's own capability with energy and growth regulation resolve the problem. Each child has a powerful and resilient ability to eat the right amount of food in order to grow in accordance with his or her genetic endowment. However, each child needs appropriate support from parents and other care providers in order to be able to eat and grow well—to manifest that genetic endowment.

Throughout the growing up years, feeding demands a division of responsibility, with parents and other care providers providing appropriate food and children being allowed to eat as much or as little as they want of what their grownups provide. Depending on the child's stage of development, the division of responsibility plays out in different ways:

- **The infant eats and grows best when he or she is fed on demand, with parents and other care providers guiding feeding based on information coming from the child with respect to timing, tempo, amount and level of skill.**
- **The older baby eats and grows best when parents and other care providers observe the child's individual sequence of oral-motor development and provide appropriately modified food to support the child's gradual transition from semi-solid food to soft table food.**
- **The toddler, preschooler and older child eat and grow best when they have both structure and support. Parents and other care providers of older children are responsible for the *what, when* and *where of feeding*; children remain responsible for the *how much* and *whether* of *eating*. This division of responsibility continues to be essential throughout the growing-up years.**

Professionals who work with children are in a powerful position to teach and support parents in effective, stage-appropriate feeding. Moreover, professionals can help parents accept each child's consistent growth pattern, even when that pattern is outside statistical cutoff points. Finally, early childhood professionals can do early intervention in response to feeding complaints or minor growth divergences. With early intervention, those minor issues can be kept from exacerbating into seriously distorted feeding and weight patterns.

For Further Information

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