



Children, The Feeding Relationship, and Weight

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Coping with child overweight is hard on everyone: children, parents and professionals. Practitioners surveyed complained that they didn't know how to teach parenting, use behavioral management or address family conflicts. The majority recommended seemingly modest interventions: "changes in eating patterns" and "limitations of specific foods." Half or more used "low-fat diet" (especially low-fat milk) and "modest calorie restriction" for adolescents.^{1,19} Encouraging parents to restrict food intake exacerbates the tendency to overweight. Restrained feeding undermines the parent-child relationship, disrupts the child's learning with respect to eating attitudes and behaviors, and increases the child's risk of weight acceleration throughout life.

The alternative to food restriction is not nutritional anarchy. Instead, it is optimizing feeding: maintaining a division of responsibility with feeding, and trusting children to grow in the way nature intended. Parents are responsible for the *what, when* and *where* of feeding. Children are responsible for the *how much* and *whether* of eating.

Child overweight can be prevented from birth by optimizing feeding. Child overweight at all ages can be treated by correcting disruptive influences and restoring optimum feeding. It is normal for each child to eat the right amount to grow predictably in accordance with his or her genetic endowment. Properly enacted in a stage-appropriate fashion, the division of responsibility provides children with both structure and support for eating. When adults do their jobs with feeding, children are effective about doing their jobs with eating—and growing.

Trusting children in the context of appropriate feeding to eat

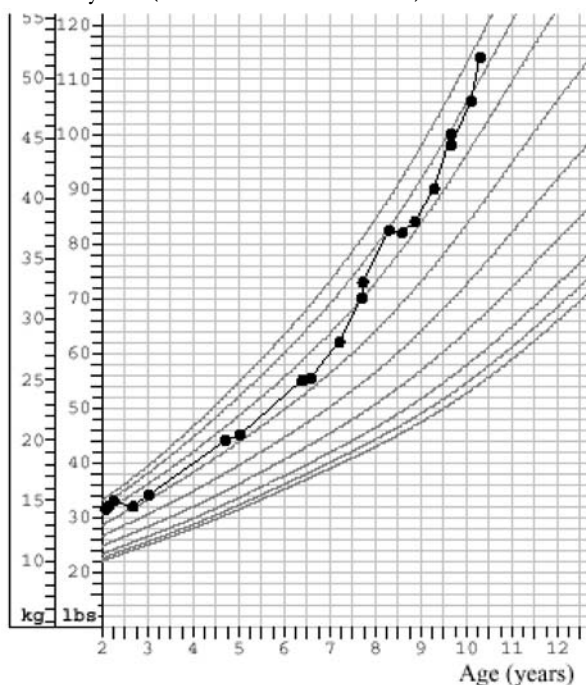
and grow appropriately requires redefining child overweight, not as high weight per se, but as weight acceleration. Such acceleration can be identified by examining longitudinal growth records for the individual child. Arbitrary cutoff points, such as 95th percentile weight for height or BMI, are necessary for calibrating population-wide trends, but are not appropriate for evaluating the individual child.

Haley, who "shot off the scale"

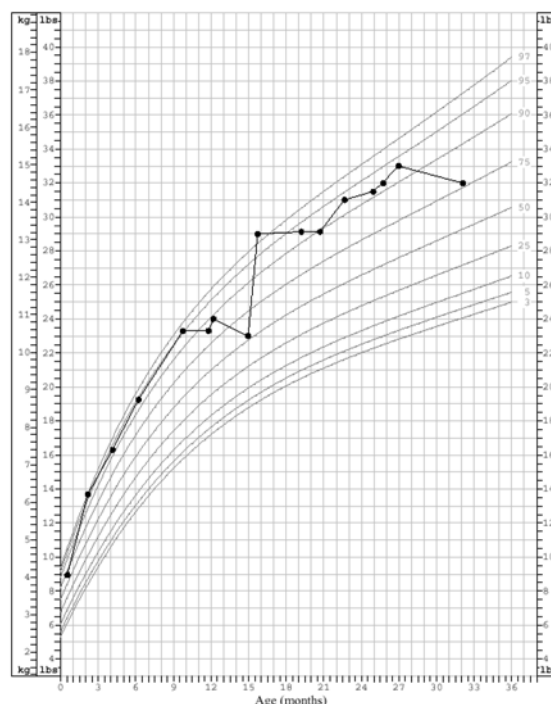
Consider 10-year-old Haley, reported by her mother to have "gained a huge amount of weight—shot off the scale." Haley's weight for age record from two to 10 years, Figure 1, shows that after remaining stable at the 75th percentile from age 2½ to seven years, her weight over the following three years had accelerated from the 75th to the 95th percentiles. When Haley was 8½ years old, her weight increase and reportedly out-of-control eating led her doctor to advise, "Eat less fat, more fiber, more fruits and vegetables, send food to the sitter." When Haley was 10, the dietitian recorded "strange food cravings—mother finds half-eaten sticks of butter and jars of honey. Haley dislikes the healthy food her mother prepares for her." The dietitian emphasized healthy eating, following the Food Guide Pyramid.

A videotape of family meals when Haley was 10 showed feeding to be rigidly restrained. The professional advice had exacerbated her parents' restricting tendencies and produced a drab, low-fat, high-fiber, high-carbohydrate, high-fruit-and-vegetable, unappealing diet that Haley detested. Haley's parents limited her portion sizes, kept butter and salad dressing away from her, and

Weight-for-Age Percentiles
2 - 20 years (Sex: F DOB: 7/3/1990)



Weight-for-Age Percentiles
Birth - 36 mos. (Sex: F DOB: 7/3/1990)



forced her to eat food she loathed. Haley’s parents impressed upon the sitter and school nutrition staff the necessity for similar restraint. Haley got around them all, taking multiple portions from the food lines, trading food with the other children, eating forbidden food at friend’s houses, spending her allowance at the local convenience store and sneaking food at home.

Even allowing for sneaking, Haley’s weekly average was only 2300 calories—65 percent of recommended amounts. Children of size generally eat less, not more, than children of average weight.¹ Moreover, Haley’s “bizarre food cravings” actually represented a sophisticated tactic that children instinctively use to maintain energy balance. In response to energy deficits, children automatically choose food of high caloric density (high in fat or sugar) to supply needed energy.²

Haley’s problems were social as well as nutritional. Being labeled an out-of-control eater increased her salience as a target for teasing. Rather than helping her to manage the teasing, her parents agreed with her tormenters that she was too fat and that it was her own fault for failing to adhere to their dietary prescriptions.

Since deprivation was so clearly not working for Haley, more deprivation was not the solution. It had already been tried and had failed repeatedly. As indicated by Figure 2, Haley had been large from birth. Although her weight for age had plotted consistently at the 95th percentile, at the 10-month visit, Haley’s physician observed “weight too much.” In response to the physician’s comment, Haley’s parents began restricting her food. By age 12 months, Haley’s weight dropped to the 75th percentile. But the physician noted, “tendency to obesity,” stimulating Haley’s parents to restrict even more.

One can only hope that Haley’s 15-month, 50th percentile plotting was a measurement error rather than frank starvation. Whatever the magnitude of her energy deficit, the clinical

record at 16 months gave evidence substantiating her mother’s complaint that Haley had a “voracious appetite.” Haley’s aggressive food scavenging overcame her parents’ attempts to withhold, and Haley’s weight accelerated to above the 97th percentile. In response to food restriction, she became food preoccupied and prone to overeat when she got her chance. At that young age, she had developed a pattern of restraint and disinhibition, characteristic of binge-eating disorder.

Haley’s parents were so intent on slimming her down that they didn’t recognize the degree to which food restriction undermined their relationship with Haley and distorted her social, emotional, and nutritional development. Rather than nurturing and providing, her parents deprived. Rather than being able to develop autonomy within reasonable structure and limits, Haley continually struggled with her parents for food. Because Haley was always hungry and unhappy, harmonious relationships and rewarding parenting were simply out of the question. In the process, Haley learned to use food for emotional reasons.

When Haley was 18 months old, her nutritional fortunes improved. The family moved, her new physician was sanguine about her weight, her mother was in school, and her father took over feeding. Over the next 4½ years, Haley’s weight stabilized at the 75th percentile. But the good times didn’t last. When Haley was 6½ years old, the family again moved. Mother, a rigidly restrained eater, again took over feeding, and Haley immediately began gaining weight. Since she had been sensitized to food deprivation as an infant, she rapidly reverted to food preoccupation and proneness to overeat. Stress from the move exacerbated her proneness to overeat and gain weight.

Teaching parents about normal growth

The solution for Haley and her family was to restore the division of responsibility in feeding and allow her to recover her

capability with food regulation and growth that she had demonstrated twice before, from birth to age 10 months and from age three to 6 ½ years. Defining child overweight as the 95th percentile led both Haley's early pediatrician and her parents to distort Haley's feeding and precipitate weight gain. This restrained feeding probably deprived Haley of the natural slimming that occurs as babies become more active. Large infants and toddlers have a 75 percent likelihood of slimming down and the large preschooler nearly that. It is only at age nine to 11 that the likelihood of retaining child overweight increases to over 50 percent.³

In the context of today's concern about child overweight, Haley's parents needed help recognizing Haley's growth integrity and ability to regulate food intake. Both pediatricians missed this opportunity. Uncorrected, the parent's perception of Haley as a voracious eater with a tendency to gain weight set her up for the later struggles that caused her weight acceleration.

Haley's parents contributed to the problem, as well. Less controlling and agenda-driven parents would have recognized the consequences of food restriction to their child and their relationship, and given it up. Healthy parents discard destructive advice and maintain their priority of healthy parenting. However, in the context of today's hysteria about child overweight, even such wise and responsible parents have to live with the guilty fear that they have condemned their child to a lifetime of overweight.

Recommendations

Understanding feeding dynamics offers the practitioner practical, achievable, and helpful approaches to weight management at the same time as it teaches and supports parenting, family interaction, and behavioral management. Children eat and grow best when they have both structure and support. Throughout the growing-up years, parents are responsible for the *what, when* and *where* of feeding; children remain responsible for the *how much* and *whether* of eating.

As providers we can help in the following ways.

First, develop a sound understanding of child development, feeding and food selection⁴ and issues related to child overweight.⁵ Many current feeding recommendations that distort feeding and undermine food regulation, are based on common practice rather than supported by research.

Second, set an agency-wide primary-intervention policy: All parents shall be given education and primary intervention on the division of responsibility in feeding, stage-appropriate feeding, and accepting consistent growth. Third, do agency-wide training and be consistent in your messages about feeding and growth.

Fourth, track children's longitudinal growth and routinely ask feeding questions, particularly at the first signs of growth divergence—either acceleration or faltering. At times, a blip is just a blip and everything is going fine. Other times, as in Haley's case, early growth blips are signs of greater problems to come and give opportunities for early intervention.

Finally, distinguish among primary, secondary, and tertiary intervention. Established problems such as Haley's require detailed evaluation and behavioral treatment planning, as well as follow-up. The plan may include a tertiary referral. To establish and maintain a division of responsibility with feeding, parents must be reasonably functional—emotionally, socially, and situationally. Internal conflicts or life circumstances that push parents

outside functional limits must be addressed in order to allow them to feed in a positive fashion. If those circumstances cannot be resolved, resist the temptation to impose food restriction on the child. Living in an over-controlling or under-supportive family is already stressing the child. Being forced to go hungry only makes things worse.

Ellyn Satter, M.S., President of Ellyn Satter Associates in Madison, Wisconsin, is the author of How to Get Your Kids To Eat But Not Too Much, as well as other books. For a complete list of references please contact the author.

References:

- 1 Rocandio, A.M., L. Ansotegui, and M. Arroyo. "Comparison of Dietary Intake Among Overweight and Non-Overweight Schoolchildren." *International Journal of Obesity and Related Metabolic Disorders*. 2001:25:1651-5.
- 2 Kern, D.L., L. McPhee, J. Fisher, S. Johnson, and L.L. Birch. "The Postingestive Consequences of Fat Condition Preferences for Flavors Associated with High Dietary Fat." *Physiology and Behavior*. 1993:54: 71-76.
- 3 Satter, E.M. *Child of Mine: Feeding With Love and Good Sense*. 2000.

Corrections to Satter EM. Children, the feeding relationship, and weight. *Maryland Medicine*. 2004; Summer:26-28.

Somehow the references got stirred during the publication process. On page 26, the citation 1,19 is as follows:

1. Barlow SE, Trowbridge FL, Klish WJ, Dietz WH. Treatment of Child and Adolescent Obesity: Reports From Pediatricians, Pediatric Nurse Practitioners, and Registered Dietitians. *Pediatrics*. 2002;110:229-235.

Then the text starts the references over beginning on page 27 with number 1. Those references match up as follows.

1. Rocandio AM, Ansotegui L, Arroyo M. Comparison of dietary intake among overweight and non-overweight schoolchildren. *International Journal of Obesity and Related Metabolic Disorders*. 2001;25:1651-5.
2. Kern DL, McPhee L, Fisher JO, Johnson S, Birch LL. The postingestive consequences of fat condition preferences for flavors associated with high dietary fat. *Physiology and Behavior*. 1993;54:71-76.
3. Serdula MK, Ivery D, Coates RJ, Freedman DS, Williamson DF, Byers T. Do obese children become obese adults? A review of the literature. *Preventive Medicine*. 1993;22:167-177.
4. Satter EM. *Child of Mine: Feeding With Love and Good Sense*. Palo Alto: Bull Publishing; 2000.
5. Satter EM. *Your Child's Weight...Helping Without Harming*. Madison, WI: Kelcy Press; 2005.