Responsive Feeding and the Division of Responsibility

Dear Editor,

We read with interest the Symposium articles on Responsive Feeding (1–5) and applaud The Journal of Nutrition for this Symposium as it rightly places focus on the importance of the feeding relationship to early childhood physical and mental well-being.

We wish to comment on two of the articles: the article by Engle and Pelto, “Responsive Feeding: Implications for Policy and Program Implementation” (5) and the article by Hurley, Cross, and Hughes, “A Systematic Review of Responsive Feeding and Child Obesity in High-Income Countries” (3).

Engle and Pelto (5) describe the division of responsibility as operationalizing responsive feeding in the United States. As it was first described by Satter in 1986 (6), the division of responsibility outlines in detail the responsive feeding relationship in which parents are responsible for the developmentally appropriate structure and routine of feeding (the what, when, and where of eating) and the child is responsible for how much and whether or not to eat what the parent provides. In the United States, where overconsumption is common and the family meal is undermined, the division of responsibility model provides the needed emphasis on structured feeding that supports self-regulation.

In the United States, the division of responsibility model should be the starting point for promoting positive and responsive feeding practices and has been relied on for decades by practitioners and organizations. The model is recognized as the best-practice childhood feeding model by the American Dietetic Association and the American Academy of Pediatrics. Feeding in the Head Start Program is conducted in accordance with division of responsibility principles. The principles also form the basis for certification of the Supplemental Food Program for Women, Infants and Children (WIC) and they are the foundation for related core message development by the USDA Food and Nutrition Services. At the local level, dietetic practitioners, and pediatric healthcare providers rely on the model to teach feeding practices to parents.

In Santa Clara County, CA, implementation of the model across multiple sectors of healthcare, public health, and community organizations serving families shows the model is relevant across cultures, incomes, and languages (we currently teach in English, Spanish, and Vietnamese).

Given our experience and the degree to which the division of responsibility is accepted and implemented, we recommend more consistent and expanded policies promoting the division of responsibility, including within the new ChooseMyPlate preschool recommendations, Supplemental Nutrition Assistance Program (SNAP) nutrition education programs, and in the implementation of the new Institute of Medicine (IOM) Early Childhood Obesity Prevention Policies (7).

Recommendations and support for responsive feeding by this Journal, the IOM, and the international movement has brought new energy and dialogue to child feeding practices. The goals of division of responsibility and responsive feeding are identical and give strong support for behavioral approaches to feeding.

Hurley, Cross and Hughes (3) find a consistent relationship for nonresponsive feeding and high child weight status. In the context of the division of responsibility, the research review focuses only on parental involvement with the child’s responsibilities of how much and whether or not to eat what the parent provides and overlooks the parent’s implementation of their responsibilities of what, when, and where the child eats. Anderson and Whitaker (8) found that the presence of family mealtime routines reduced the odds of obesity in preschoolers by 23%, and they identified household routines, including mealtime, as promising targets for obesity prevention. The article by Hurley, Cross and Hughes would be strengthened by reviewing this aspect of the feeding relationship.

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Literature Cited


