Giving children autonomy with eating: What it is—and isn’t

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For parents in your practice to score high on sDOR.2-6y, education must be compatible with the Satter Feeding Dynamics Model (fdSatter) and the Satter Division of Responsibility in Feeding (sDOR). fdSatter is a child-competence model based on evidence-based concrete principles and practices,1 tested with the validated sDOR.2-6y.2 fdSatter and sDOR avoid stipulating “healthy” food and recommend against all pressure and restriction. Eating Competent parents’ (those who score high in ecSI 2.0) following sDOR.2-6y is associated with lower child nutrition risk.2 Intervention consistent with fdSatter defines child outcomes not as the children’s dietary quality or avoiding BMI extremes, but in terms of children’s Eating Competence—their positive eating attitudes and behaviors.

From the fdSatter/sDOR perspective, giving children autonomy with eating means giving unreserved permission to children to determine what and how much to eat of food parents provide for them at regular meals and sit-down snacks. This permission gives children agency with eating: within the context of parent leadership, they can act independently and make their own free choices about what and how much to eat. Autonomy items on sDOR.2-6y include:2

- If I think my child hasn’t had enough, I try to get him or her to eat a few more bites. (reverse scored)
- I let my child eat until s/he stops eating and doesn’t want more.
- I struggle to get my child to eat. (reverse scored)

fdSatter, sDOR are based on child competence

fdSatter and sDOR are based on trust in children’s competence with eating, even when children show extreme eating attitudes and behaviors and patterns of consistent growth outside the limits defined by health policy as “overweight,” “obesity,” and “failure to thrive.”

Trust in child competence with eating is based on children’s biopsychosocial processes:

- Hunger and the drive to survive
- Appetite and the need for pleasure
- The social reward of sharing food
- The biological propensity to show growth tracking

Children push themselves along to learn to eat the food parents eat, even through they . . .

- Refuse new foods at first
- Are inconsistent about what they eat
- Are more or less skeptical about unfamiliar food
- Are more or less sensitive to tastes and textures
- Are more or less enthusiastic about food and eating
- Eat more, less, or different food when they are excited or upset
- Are inclined to maintain preferred and stable body weight
- Are more or less typical developmentally and neurologically

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“Responsive feeding” research is inconsistent with fdSatter, sDOR
While fdSatter and sDOR are responsive feeding, the opposite is not true, and the “responsive feeding” approaches outlined here are likely to produce lower sDOR.2-6y scores. “Responsive feeding” is a loosely defined approach that varies with the researcher/educator. From the early WHO publication endorsing seeking methods to verbally encourage children to eat,3 current “responsive-feeding-based” nutrition research takes a child-deficit stance and looks for ways to get children to eat appropriate (e.g. “healthy”) food in appropriate (e.g. externally determined) amounts.

Child-deficit assumptions in responsive feeding research
- Children will not voluntarily eat fruits and vegetables,4-6 increase food variety.7
- Some child genetic predispositions are obesogenic:8 enjoying food and eating,9 having high fat-preference scores,10 having lower ability to delay gratification and tolerate frustration,11 showing erratic temperament, negativity,12 and impulsivity,13, having a sense of loss of control over eating.14
- Food availability in today’s world overwhelms children’s ability to regulate food intake,15 as does formula-feeding,16 early solids introduction.17
- Big and rapidly growing children regulate poorly.18

Child-deficit strategies in responsive feeding research:
- Use autonomy support,19 child-centered practices,20 covert non-directive strategies,21 responsive feeding and nondirective control,22 do encouragement through negotiation,23 encourage, praise,19 do elaborate modeling,22 prompt, reward, bargain,4 allow choosing appropriate food.20
- Give children guidance on appropriate self-regulation,19 teach children to internally regulate,24 self-limit portion sizes,19 delay gratification,25 reference their internal state during eating (“are you full?”).26
- Use structure as covert control:19, 21, 27 emphasize "healthy" food, identify family values (eat vegetables, not candy),19 avoid eating out, purchasing “unhealthy” food,27 do selective availability of food in the home.21
- Enhance fruit, vegetable (FV) intake by using positive 28 or responsive pressure,29 nondirective control,28 get children to associate pleasure with eating healthful food in moderate amounts,19 mix FV with food the child likes,6, 22 serve vegetables first,5 increase vegetable portion size,30 make FV available for PRN eating.22
- Control food selection, portion size to manage child food regulation: avoid high energy density food, large portion sizes,31, 32 bottle-feeding,16 early solids introduction.17

The take-home message
Manipulating children’s eating in any way to achieve specific nutritional or growth outcomes is inconsistent with fdSatter and sDOR and is likely to result in lower sDOR.2-6y scores. This manipulation can be subtle, so pause before you follow well-worn pathways. Do you have an agenda for what/how much the child shall eat? Are you taking away the child’s permission to eat or trying to get the parent/child to eat certain foods or certain amounts of food? If so, your nutrition counseling is inconsistent with sDOR.

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