FAMILY MEALS FOCUS
Article 12

Children and Weight: How to Help Without Harming

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The Satter Feeding Dynamics Model (fdSatter) recommends addressing children's weight by supporting internal regulation and the evolution of growth that is normal for the individual child. [1, 2] But how do you integrate that stance when you have a referral for weight reduction intervention with an "overweight" or "obese" child? More than likely the diagnosis was made on the basis of United States health policy, which defines "healthy" child weight as being between the 5th and 85th percentiles, child "overweight" as at the 85th to 95th percentile, and child "obesity" as at the 95th percentile or greater. Parenthetically, "underweight" is defined as less than the 5th percentile. Intensive lifestyle intervention is recommended for two-year-olds whose W/H ≥95th %tile,[3] and six-year-olds whose BMI ≥95th %tile. [4]

While fdSatter is weight-neutral, that is not to say that anything goes with respect to child weight – or adult weight, for that matter.

Emphasize consistent growth trajectory

Children are powerfully inclined to grow consistently. Striving for weight loss or even weight stabilization doesn't work. As outlined in a related issue of Family Meals Focus[5] metanalysis shows even multidisciplinary, long-term, specialty-clinic child weight intervention to be only marginally effective[6, 7] (if you can use the word "effective" to describe getting children to eat less and exercise more to lose weight). Less-intensive intervention is not "effective" at all. [6] Moreover, the diagnosis itself is likely to be obesogenic[8 9 10] *and* it is likely to do harm in other ways: interfering with children's natural growth trajectory (which may include diverging to a lower percentile) [11-14 15] and impairing child[16] and parent self-regard. [17]

Do get involved

Avoiding weight-loss intervention is not the same as taking a hands-off approach. While fdSatter is weight-neutral, that is not to say that anything goes with respect to child weight—or adult weight, for that matter. While weight is strongly genetically determined, disruptive factors may exist in the family and in the environment. Pronounced and prolonged disruptions can distort a child's natural growth trajectory. Identify and correct the disruption. Establish the Satter Division of Responsibility in Feeding (sDOR) to support the child's natural growth integrity, preserve the feeding relationship, and protect the child's long-term relationship with food: their Eating Competence.[18]

The fdSatter approach: Identify issues

Professionals trained in the fdSatter-based Ellyn Satter Institute *Feeding with Love and Good Sense VISION* workshop take seriously referring health professionals' concerns about the child's weight. Professionals using a Satter-consistent approach acknowledge there *is* a problem. The exact *identity* of the problem is another story. To identify that problem, they examine the child's weight pattern in detail to sort out what is really going on with them.

Misinterpretation of normal growth

Does the child's growth follow a consistent trajectory? Consistent growth gives evidence that things are going well for the child medically, nutritionally, and psychosocially.[19] Children have a strong and resilient tendency to eat the right amount of food to grow consistently in accordance with their genetic endowment. Even if a child's W/L or BMI is ≥85th or even ≥95th percentile, it is likely to be normal growth when the child grows consistently along that high percentile or shows a consistent z-score. [20] Understand what causes divergences in height and weight beyond calories in/calories out.[19] The normal-growth label can apply to catchup growth if a child was born particularly small, catch-down growth if they were born particularly large, and adjustment to mid-parent size over the first four to seven years. Such natural growth adjustments tend to be slow and smooth and continue for months and even years. Sometimes divergence is only a natural growth blip: ruling out disruptive factors sorts out normal from distorted growth.

Parents' see child's weight as too high and strive for weight loss

Having determined that the child's growth follows a consistent trajectory, the next step is to address parent attitudes and behavior relative to the child's weight. Do they feel the child's weight is too high? Do they accept the "obesity/overweight" label and try to get the child to lose weight? In contrast, do they ignore the "obesity/overweight" label and refuse to participate in weight reduction intervention? Even if the child's weight trajectory is consistent, labeling/intervening parents benefit from careful assessment of underlying issues as defined below. Their child could have such powerful and resilient homeostasic mechanisms that they maintain a consistent weight trajectory despite chronic restrained feeding, poor feeding practices, and/or stress. On the other hand, ignoring/intervention-avoiding parents are likely to be doing well with feeding and simply need support. They are good candidates for a primary-care session or two, teaching sDOR and giving support with respect to identifying and addressing advice and other factors that could interfere with their child's consistent growth.

Restrained feeding, poor feeding practices, stress

Assessment as taught in the *Feeding with Love and Good Sense VISION* workshop identifies families who are likely to benefit from secondary intervention. That intervention is a several-session treatment plan to establish sDOR, with particular attention to establishing structure and distinguishing interference with the child's eating autonomy. [21] A child's rapid weight acceleration, including acceleration between the 5th and 85th percentiles, is likely to indicate growth disruption. Identifying the source of that disruption requires detailed assessment of the

child's past and present issues: medical, nutritional, developmental, psychosocial, feeding dynamics, and parent Eating Competence.[18] The assessment and treatment-planning process identifies the components of the problem and allows parents to feel that they, their child, and their situation are fully understood. Without a detailed workup, advice to follow sDOR comes across as just one more of the many partial and piecemeal bits of instruction parents have been given over the years. Once sDOR is defined in individualized and achievable ways, parents need support in establishing structured meals and snacks and taking and maintaining the leap of faith necessary to let their child do the *how much* and *whether* of *eating.* To take that leap of faith, parents need help recognizing the child's emerging ability to regulate their food intake.

Identify complicating, exacerbating issues

Assessment also identifies families who require tertiary intervention before they can be successful with sDOR-based treatment. Such families have underlying or exacerbating issues that require referral to medical, mental health, or social welfare professionals. A child's diabetes might be poorly controlled or a family crisis, such as COVID, may overwhelm parents' ability to provide structure and predictability. A parent's Eating Competence (EC)[18] could be so low that they are unable to provide structure with feeding or give the child autonomy with eating. A family's psychosocial functioning could contribute to the problem: a family might be chaotic on the one hand or parents could be rigid and controlling on the other. The family could be experiencing such strained economic circumstances that it undermines their overall functioning. Once complicating, exacerbating issues are addressed, the family can be referred back to a fdSatter/sDOR trained professional for sDOR-based treatment.

Report findings; Recommend individualized and achievable intervention

In accepting a referral for weight reduction intervention with an "overweight" or "obese" child you essentially have a contract with the provider to address the issue at hand. You can fulfill that contract by sharing the results of your assessment and plan. Back up your decisions by giving your provider a copy of this newsletter and of *Family Meals Focus #6 Children and weight: are current guidelines helpful?* [5]

- [Child] has a natural tendency for high body weight, is growing consistently, and parents are comfortable with [child's] weight. Parents taught sDOR and helped to identify outside interference with feeding dynamics. Followup as needed. Flag for followup with sDOR, ongoing consistent growth trajectory.
- [Child] has a natural tendency for high body weight and is growing consistently. However, parents are not comfortable with [child's] weight and have made repeated and sporadic weight reduction attempts which disrupt the feeding relationship and appear to further dysregulate the child's weight. Referred for further assessment and treatment planning.
- [Child] has achieved current weight (W/L, BMI) by accelerating from what appears to be their normal growth trajectory [beginning at what age] [between what ages]. Further historical and present-time assessment indicates [restrained feeding, poor feeding practices, low parent Eating Competence, stress] have exacerbated child's weight gain. Recommend [several-session] treatment to achieve fdSatter/sDOR with particular attention to supporting parent Eating Competence, establishing structured meals and snacks, and avoiding interference with child's eating autonomy.

- [Assessment of child's weight acceleration] identifies [restrained feeding, poor feeding practices, stress]. Eventually, recommend [several-session] treatment to achieve sDOR. However, [complicating, exacerbating issues] must first be addressed before parents can be successful with treatment. Refer to [MD, family therapist, social worker]. Flag for referral back for fdSatter/sDOR-based treatment when adjunct issues have been resolved.

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Child's Weight: Helping Without Harming **For more about following the Satter Division of Responsibility in Feeding and letting children grow up to get bodies that are right for them, see Ellyn Satter's Your Child's Weight: Helping Without Harming.**