Children Who Have Barriers to Eating

By *Ellyn Satter, MS, MSSW, Dietitian and Family Therapist*

Skye, the mother of a seven-year-old with a history of extreme food selectivity and choking, says, “The division of responsibility has caused me a great deal of stress over the years. I can't tell you how many times it has been used as expert-sanctioned advice to starve my son. Dietitians, daycare agencies, children's services, doctors, therapists—they all explain it the same. ‘You cook the food, and if your child doesn't eat, don't worry, he won't starve.’ ‘Give him what you eat, if he doesn’t eat it, he doesn’t get anything at all till the next meal. No meal, no snacks.’ ‘He won’t starve. When he’s hungry, he’ll eat.’ Um . . . it doesn't work that way. Maybe my son doesn’t actually *starve*, but he certainly isn’t *eating*. May I go out on a limb and say this is very likely *not* what you meant.”

Skye, you are so right. As you have discovered, just saying "he won't starve" is no help at all and, in fact, saying “When he’s hungry, he’ll eat” puts a *lot* of pressure on the child to eat. Pressure is what the Satter Division of Responsibility in Feeding (sDOR) is intended to avoid: Pressure does harm, not good.

Many health professionals say, “do your jobs with feeding and let your child do theirs with eating,” and that is often useful, but not if feeding is at all complicated. (That’s why I didn’t capitalize division of responsibility in your question.) In complicated cases, for sDOR to work, you have to understand it thoroughly. Conversely, if a sDOR treatment plan *doesn’t* work, there is some error in the way it is being applied: Structure is eroding or pressure is creeping in.

Consider the child’s barriers to eating

Let’s name Skye’s son Jackson, and put ourselves in his place with eating. Jackson’s conflict and anxiety about eating are simply so great that he can’t overcome those feelings on his own. Those negative feelings have likely been with him for so long and been so powerful that they have overwhelmed his natural inclination to eat any but the most-familiar food. Jackson’s history of choking and extreme food selectivity testifies to oral-motor difficulties that may have made eating difficult for him from the very first. Jackson may be temperamentally negative, shy, or slow-to-warm up. He could be so sensitive to tastes, textures, and even smells that he gags or chokes. He may have been born prematurely and much of what happened to his mouth early on was painful, or at least unpleasant.

Children who seemingly don’t eat scare everyone, even health professionals with lots of experience, and scared people tend to put pressure on feeding. Jackson’s parents have likely been on the receiving end of advice to jiggle him or the bottle, play “here comes the

airplane," make special foods, reward and cheerlead, and, yes, provide meals and expect the child to eat. Even such seemingly positive pressure makes children anxious and reluctant to eat.

Build on the child's drive to eat

Children always feel a certain amount of anxiety about eating new food. However, learning and growing is all about the *new*, and children push past their anxiety and learn to eat new food. Jackson can't do that because his anxiety is just too great. To reduce his anxiety to the level where he can manage it, reassure Jackson that he does not have to eat and, at the same time, be considerate without catering with menu planning.

Be considerate without catering

Jackson wants to be successful with eating at family mealtime, and to be successful he needs to see something that he can eat. Because of his eating history, he has missed out on years of food experience, and much of what his parents eat remains new to him. Other children become familiar with food by seeing it at meals and watching their parents eat it. For Jackson, meals have been so unpleasant and he has been so anxious for so long that he couldn't learn by watching.

Jackson's parents can help him, not by limiting their menus to food that he eats—that applies another sort of pressure—but by including one or two foods that Jackson generally eats. Food that he generally eats would be a side dish, not an alternative entrée—say something such as bread, rice, or fruit. Make enough to go around with leftovers—that keeps it from looking like it was made especially for him. Another way of saying this is to match familiar and accepted food with unfamiliar and not-yet-accepted food. Then Jackson needs to be allowed to do his own eccentric version of *whether* and *how much*, even if he eats nothing but slice after slice of bread day after day. Eventually he will get enough bread and look around for something else to eat. Even in the extremely unlikely case that he continues to subsist on bread, what can be done about it? Enticing or forcing him to eat other foods will take him and his parents right back to where they started.

From the sDOR perspective, Jackson's eating a variety of food isn't the point. The point is letting him and his parents have enjoyable family meals. Think of how joyful it is for Jackson and his parents to go to meals relieved of worry about what and how much he eats! Such worry doesn't just crop up at mealtime—it follows parents and children around. Parents who establish sDOR say they and their child feel better all day. Pleasant meals let Jackson develop positive food acceptance attitudes and behaviors. He can participate comfortably in family meals, remain calm in the presence of unfamiliar food, watch his parents eat, pick and choose from what is available, and say yes, please and no thank you. In the process, he gets repeated neutral exposure to a variety of food and will, ever-so-gradually, broaden out his food repertory.

Depend on repeated neutral exposure

Even the most traumatized, cautious, and sickest child retains the drive to learn to eat, and, because of it, they can be trusted to push themselves along. You can trust them, that is, provided adults support them by reducing their barriers to eating. At first, trusting children's

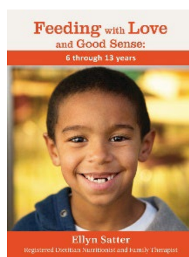
drive to eat can be an anxiety-provoking challenge for both professionals and parents. As health professionals, we have to contain our own anxiety and be careful not to pass it on to already-anxious parents, either subjectively with our attitudes or concretely in the form of unrealistic feeding advice. As Skye's story illustrates, pressure is like a hot potato that gets tossed around until it ends up in the lap of the person least able to cope with it. In too many cases, pressure on the health professional (to keep the child alive and well) gets tossed to parents (to get the child to eat), who toss it to the child in the form of feeding pressure.

Even without pressure, it can take *years* for Jackson to learn to eat a variety of food. Some children approach their teens before they begin to expand on the limited number of foods they eat. That is just the way some children are: They are perfectly comfortable with eating the same foods meal and after meal—maybe eating a lot at a meal that appeals to them. They aren't much fun to cook for, but parents need to remember that they are cooking for themselves and inviting their child to join in; They aren't learning to eat off the high-chair tray! Then for whatever reason, provided parents have hung in there with sDOR in the meantime, those cautious eaters branch out with food acceptance. For them it is no big deal. For parents is a *very* big deal, but saying so puts pressure on the child's eating. Parents can share a glance with each other when their child matter-of-factly eats something new, but that's it.

Trauma turned into success story

In most cases, longstanding, entrenched feeding problems such as Jackson's only respond to the detailed assessment and sDOR-based treatment planning and intervention that is taught in the Ellyn Satter Institute *Feeding with Love and Good Sense VISION Workshop.* Careful assessment identifies what brought parent and child to this place with feeding and allows parents to feel that they, their child, and their situation are fully understood. Without this detailed assessment, 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.

Skye was the exception. She studied *Child of Mine* to fully understand sDOR and applied the advice all on her own. "Like I said to start with, what I was told for years was sDOR was nothing of the sort. It's been only a few days—maybe a week—and I already see a huge improvement. I actually enjoy family meals now. I can't remember ever looking forward to them. I never thought I would, and yet, here we are."



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