

The Satter Feeding Dynamics Model (fdSatter) is a clinically and research-grounded, practical, and theoretically sound understanding of and trust in normal child development, including growth, based on children's natural behavioral, nutritional, psychosocial, oral-motor, and physical abilities and functioning.¹⁻¹² fdSatter is competency based: Children are inclined toward mastery as well as skeptical of new food. Provided adults give children appropriate support, repeated neutral exposure to food, and don't interfere, restrict, or pressure with what or how much they eat, children eat as much or little as they need,^{13, 14} gradually accept new food,¹⁴⁻²¹ and maintain energy balance and consistent growth^{13, 22, 23} that reflects their genetic endowment.^{24, 25}

The Satter Division of Responsibility in Feeding

fdSatter is implemented by the Satter Division of Responsibility in Feeding (sDOR). sDOR responds to children's predictable patterns with respect to psychosocial^{26, 27} and oral-motor^{28, 29} development. sDOR translates authoritative parenting into parenting with food, supporting parents in taking kind and nurturing leadership with feeding and giving children trusting and respectful autonomy with eating. Children of authoritative parents are less likely to be obese^{30, 31} or be characterized as picky eaters.³²

sDOR.2-6y™ achievably tests nutrition risk

Assessing adherence to sDOR gives parents and professionals an achievable way to address their biggest feeding worry: that children are doing well nutritionally.³³ Parent adherence to sDOR is measured by the validated sDOR.2-6y³³ Parents who were observed to follow sDOR³⁴ and also scored high on sDOR.2-6y trusted their child to eat what and as much as they wanted from what parents provided and avoided feeding pressure and restriction.³³

sDOR.2-6y™ directly assesses sDOR adherence in parents of 24- to 72-month-old children^{33, 34} by addressing both and only the degree to which parents take leadership with feeding and give their child autonomy with eating. Correlation with other validated questionnaires indicates that children of parents who follow the Satter Division of Responsibility in Feeding, who score high on sDOR.2-6y™, have lower nutritional risk. Parents who test high on sDOR.2-6y™ have higher Eating Competence as measured by ecSI 2.0™,³⁵ better sleep quality and psychosocial functioning, lower stress, and lower levels of uncontrolled or emotional eating.³³

Children become healthy eaters

When parents follow sDOR, children get repeated neutral exposure to food, thus allowing them to become healthy eaters. Healthy eating doesn't mean they enthusiastically eat everything that is put before them (but not too much). It means they grow up with eating attitudes and behaviors that are consistent with the Satter Eating Competence Model:³⁶ They feel good about eating, are comfortable in the presence of unfamiliar food, eat as much as they need to grow predictably, and are relaxed about joining in with family meals and structured snacks. These positive eating attitudes and behaviors, in turn, allow children to push themselves along to learn to eat the food their trusted grownups eat and, over time, gradually eat a greater variety of food.³⁷ The goal of sDOR is not to get children to eat target foods *today*: It is to allow them to

enjoy a variety of food for a lifetime. It can take years for some children to grow out of their natural food skepticism.^{20, 21}

Agencies recognize positive feeding dynamics

Agencies such as the Food and Nutrition Service of the US Department of Agriculture, Special Supplemental Nutrition Program for Women, Infants, and Children, Head Start, the American Academy of Pediatrics, and the Academy of Nutrition and Dietetics endorse positive feeding dynamics, although they tend to use the term *responsive feeding*. While sDOR is responsive feeding, not all responsive feeding is sDOR. Feeding guidance is inconsistent with fdSatter and sDOR and likely to produce low scores on sDOR.2-6y™ when children are viewed as being incapable—as having biopsychosocial deficits—and prompted or managed in some way to get them to eat healthy food, eat more or less, and/or gain more or less weight than they do naturally. Essentially pressuring and/or restricting child-deficit approaches include negotiation, praise, nondirective control, elaborate modeling, rewarding, or bargaining. Strategies deemed “positive” or “responsive” pressure are also inconsistent with sDOR. These include logic or reasoning, teaching nutrition goals or giving good-food-bad-food lists, teaching internal regulation and/or portion sizes, teaching children to delay gratification, reflect on how their stomach feels before, during, and after eating, and expecting them to base food consumption on family values (eat fruits and vegetables, not candy). Attempts beyond repeated neutral exposure to increase children’s fruit and vegetable intake are inconsistent with sDOR. These include mixing vegetables with food the child likes, serving vegetables first, increasing vegetable portion size, and making fruits and vegetables available for eating as desired throughout the day. It is inconsistent with sDOR to use structure as a mechanism for covert control by emphasizing “healthy” food for both parents and children, avoiding eating out and/or purchasing “unhealthy” food, and stressing selective availability of food in the home.

sDOR supports children’s capability

Children—even those who are ill or need particular help with maintaining their nutritional status—are born *wanting* to eat, knowing *how much* to eat, and able to *grow* in the way nature intended for them. The task of their grownups—parents, teachers, and their advisors—is to raise them to have positive eating attitudes and behaviors. Setting aside efforts to get children to eat certain amounts and types of food allows their grownups to support them in learning to enjoy a variety of food for a lifetime.

References

1. Satter EM. The feeding relationship: problems and interventions. *The Journal of pediatrics*. 1990;117:S181-S189. Computer.
2. Satter E. Internal regulation and the evolution of normal growth as the basis for prevention of obesity in childhood. *J Am Diet Assoc*. 1996;96:860-864.
3. Davies WH, Satter E, Berlin KS, et al. Reconceptualizing feeding and feeding disorders in interpersonal context: the case for a relational disorder. *J Fam Psychol*. 2006;20:409-417.
4. Satter E. The Satter Feeding Dynamics Model of child overweight definition, prevention and intervention. In: O'Donahue W, Moore BA, Scott B, eds. *Pediatric and Adolescent Obesity Treatment: A Comprehensive Handbook*. Taylor and Francis; 2007:287-314.
5. Satter E. Childhood eating disorders. *J Amer Diet Assoc*. 1986;86:357-361.

References cont'd

6. Satter E. The feeding relationship. *J Am Diet Assoc.* 1986;86:352-356.
7. Satter E. The feeding relationship: problems and interventions. *J Pediatrics.* 1990;117:S181-S189.
8. Satter E. Feeding dynamics: helping children to eat well. *J Pediatr Health Car.* 1995;9:178-184.
9. Satter E. A moderate view on fat restriction for young children. *J Amer Diet Assoc.* 2000;100:32-36.
10. Satter E. Letter to the editor: Promoting "healthy" food in the context of internal regulation of eating: Comment on Slusser et al. *Child Obes.* 2013;9:557-558.
11. Satter E, Lohse B. Letter to the editor: The quest for children's food acceptance. *Journal of the Academy of Nutrition and Dietetics.* 2013;113:508-509.
12. Satter E. Letter to the editor: Testing Satter's Division of Responsibility in Feeding in the context of restrictive snack-management practices. *Am J Clin Nutr.* 2014;100:986-987.
13. Fomon SJ, Filer LJ, Jr., Thomas LN, et al. Influence of formula concentration on caloric intake and growth of normal infants. *Acta Paediatr Scand.* 1975;64:172-181.
14. Birch LL, Deysher M. Caloric compensation and sensory specific satiety: Evidence for self regulation of food intake by young children. *Appetite.* 1986;7:323-331.
15. Birch LL, Fisher JO. Appetite and eating behavior in children. *Pediatr Clin North Am.* 1995;42:931-953.
16. Addressi E, Galloway AT, Visalberghi E, et al. Specific social influences on the acceptance of novel foods in 2-5-year-old children. *Appetite.* 2005;45:264-271.
17. Wardle J, Herrera ML, Cooke L, et al. Modifying children's food preferences: the effects of exposure and reward on acceptance of an unfamiliar vegetable. *European journal of clinical nutrition.* 2003;57:341-348.
18. Davis CM. Self selection of diet by newly weaned infants: An experimental study. *Am J Dis Child.* 1928;36:651-679.
19. Beal VA. Dietary intake of individuals followed through infancy and childhood. *American Journal of Public Health.* 1961;51:1107-1117.
20. Davis CM. Self-selection of food by children. *The American Journal of Nursing.* 1935;35:403-410.
21. Nas Z, Herle M, Kininmonth AR, et al. Nature and nurture in fussy eating from toddlerhood to early adolescence: findings from the Gemini twin cohort. *Journal of Child Psychology and Psychiatry.* 2024. doi:<https://doi.org/10.1111/jcpp.14053>
22. Pietilainen KH, Kaprio J, Rasanen M, et al. Tracking of body size from birth to late adolescence: contributions of birth length, birth weight, duration of gestation, parents' body size, and twinship. *Am J Epidemiol.* Jul 1 2001;154:21-29.
23. O'Connor EA, Evans CV, Burda BU, et al. Screening for obesity and intervention for weight management in children and adolescents: Evidence report and systematic review for the US Preventive Services Task Force. *JAMA.* 2017;317:2427-2444.
24. Garn SM, Clark DC. Trends in fatness and the origins of obesity. *Pediatrics.* 1976;57:443-456.
25. Whitaker KL, Jarvis MJ, Boniface D, et al. The intergenerational transmission of thinness. *Arch Pediatr Adolesc Med.* 2011;165:900-905.
26. Greenspan S, Lourie RS. Developmental structuralist approach to the classification of adaptive and pathological personality organizations: Infancy and early childhood. *Am J Psychiatry.* 1981;138:725-735. to pull.
27. Erikson EH. Eight Ages of Man. *Childhood and Society, 2nd Edition.* W.W.Norton; 1993:242-274.
28. Kleinman RE. American Academy of Pediatrics recommendations for complementary feeding. *Pediatrics.* 2000;106:1274.
29. Morris SE, Klein MD. *Pre-feeding Skills: A Comprehensive Resource for Mealtime Development.* The Psychological Corporation/Therapy Skill Builders; 2000.
30. Kakinami L, Barnett TA, Seguin L, et al. Parenting style and obesity risk in children. *Prev Med.* 2015;75:18-22.
31. Rhee KE, Lumeng JC, Appugliese DP, et al. Parenting styles and overweight status in first grade. *Pediatrics.* 2006;117:2047-2054.
32. Podlesak AK, Mozer ME, Smith-Simpson S, et al. Associations between parenting style and parent and toddler mealtime behaviors. *Curr Dev Nutr.* 2017;1:e000570. doi:10.3945/cdn.117.000570
33. Lohse B, Mitchell DC. Valid and reliable measure of adherence to Satter Division of Responsibility in Feeding. *J Nutr Educ Behav.* 2021:211-222.

References cont'd

34. Lohse B, Satter E. Use of an observational comparative strategy demonstrated construct validity of a measure to assess adherence to the Satter Division of Responsibility in Feeding. *Journal of the Academy of Nutrition and Dietetics*. 2021;121:1143-1156.e6.
35. Krall JS, Lohse B. Validation of a measure of the Satter Eating Competence model with low-income females. *Int J Behav Nutr Phys Act*. 2011;8. doi:10.1186/1479-5868-8-26 PMC3094263,
36. Satter E. Eating Competence: definition and evidence for the Satter Eating Competence Model. *J Nutr Educ Behav*. 2007;39:S142-S153.
37. Satter E. Hierarchy of food needs. *J Nutr Educ Behav*. Sep-Oct 2007;39(5 Suppl):S187-188.

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