Maternal–Child Feeding Practices and Associations With Maternal and Child Characteristics

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We evaluated associations between maternal child-feeding practices and maternal (age, body mass index [BMI], education, disordered eating) and child (age, BMI, emotional and behavioral) characteristics in 412 mothers and their children using the Parental Feeding Practices, the Child Behavior Checklist, and the Eating Disorders Examination Questionnaires. Maternal BMI was positively correlated with covert control feeding practices. Younger maternal age and lower maternal educational level were associated with increased maternal pressure to eat and overt control in their child-feeding practices. Maternal disordered eating behaviors were associated with increased restriction and covert control in their child-feeding practices. Maternal monitoring during child feeding was associated with lower levels of the child’s problems with internalization and externalization. Finally, maternal feeding practices that involved covert control were related to higher eating restriction by the mother on herself and more maternal concern about her child’s weight. Our findings suggest that maternal feeding practices such as overt and covert control are related to both maternal and child factors.

Clinicians must become aware that these maternal feeding practices can model children’s eating behavior and disrupt children’s self-regulation of food intake; however, maternal monitoring during child feeding seems to be related to children’s well-being. Nutr Today. 2017;52(5):232–239

It is relatively common for parents to worry about their children’s eating behavior at primary care consultations, and it is also recognized that this type of concern can have adverse consequences for both children and their caregivers. There are many studies supporting parents’ descriptions of their children as being “picky” eaters, as having eating and feeding problems, or as having a poor appetite and being “faddy.”

Previous studies speculated about the eventual consequences of that kind of behavior on children’s development. For instance, the results showed that children described by their parents as having eating problems grew significantly less well during the period from birth to 2 years old. Most recently, the prevalence of feeding problems was assessed and shown to affect between 25% and 50% of children. They may evolve into minor problems at meal-times or develop into a life-threatening refusal of food. Moreover, eating problems and obesity are described as frequent problems in primary school children and can persist into adolescence, which, in turn, may cause severe psychological and physical consequences. There is some evidence that eating problems during childhood tend to persist or even become aggravated in adolescence. A recent study also confirmed that parental pressure to eat in childhood was associated with problematic eating patterns in young adulthood. Much current research is directed toward understanding the influence that parents can have on their children’s eating behavior, paying special attention to the role of parental feeding practices or strategies. According to Ventura and Birch, the feeding strategies that parents use to control both quantity and content of their children’s food intake may be an important explanation for understanding children’s eating behavior.
Feeding practices can be conceptualized as the specific strategies that parents use in an attempt to maintain or modify their child's eating style and diet, and they may include directive and nondirective strategies. Pressure to eat as a directive feeding technique results in pushing children to eat more food or to increase their intake of healthy foods. Restriction is also a directive strategy when it involves an attempt to control children's diet by restricting their access to unhealthy foods. Nondirective feeding practices, on the other hand, include monitoring children's intake of unhealthy foods and modeling healthy eating.

Central to knowledge about parental feeding practices is the concept of parental control. Ogden et al. conceptualized about the existence of 2 types of parental control: overt and covert. Overt control involves limiting the child's intake of unhealthy foods in a way that can be perceived by the child. Covert control remains undetected by the child but still results in restriction. Ogden et al. concluded that slimmer parents and those with children perceived as heavier were more likely to use covert control and those from a higher social class were more likely to use overt control. They also found that greater covert control predicted a decreased intake of unhealthy snacks, whereas greater overt control predicted an increased intake of healthy snacks.

The most well-studied feeding strategies are those focused on the controlling feeding practices, pressure to eat, and restriction of food intake. The bidirectional nature of the feeding interactions highlights that parental feeding practices may be used in response to a child's eating behavior and weight status and that parents use different feeding practices for different children in the same family. According to previous research, a child's inborn characteristics and temperament are also important predictors of maternal use of controlling feeding practices at 1 and 2 years old.

In another study, the particular focus was on maternal concerns about children being underweight and overweight, maternal feeding practices, child eating behaviors, and child body mass index (BMI). The results supported the association between pressure to eat and restriction with maternal concerns about children's weight. Fussiness about food reported by a child was a significant independent positive predictor of maternal use of pressure to eat and was partially mediated by the mothers' concern about her child being or becoming overweight. The authors also found that mothers with higher levels of concern about their children being overweight reported more frequent use of restriction and greater child food responsiveness. Similarly, another study found an association between child food avoidance, and maternal use of controlling feeding practices and the use of food for behavior regulation. Maternal dietary restraint was also found to be associated with, and significantly contributed to, predicting child food fussiness and satiety responsiveness. More recently, Morrison et al. studied the correlations between maternal eating patterns, maternal feeding practices, and child eating patterns. The authors found that maternal external eating (eating in response to outside stimuli) was the only factor that correlated significantly with both maternal control and child eating patterns and that maternal control in feeding mediated the relationship between maternal external eating and children's picky eating.

Considering older children (7–9 years old) and their families, maternal restriction associated with food responsiveness and maternal pressure to eat was associated with child satiety responsiveness, slowness, and fussiness. Children’s enjoyment of food was associated with less maternal pressure to eat. In a study of primary school children aged between 8 and 12 years, a significant relationship between maternal pressure to eat and the sex of the child suggested that more maternal pressure might lead to increases in overeating by a daughter. The authors also concluded that the continuity in eating problems in primary school over time is likely influenced by parental feeding strategies. These results support the reports of patients with eating disorder that describe unfavorable eating patterns early in life. As discussed, many results support the relationship between parental feeding practices and children's eating patterns and behaviors. Nevertheless, data about the type of parental control (whether covert or overt) are scarce, and as far as we know, the association between parental feeding practices and children's well-being is nonexistent.

The current study's objectives were (1) to assess maternal feeding practices and study their associations between mother and child variables, (2) to identify the predictors of maternal overt and covert control feeding practices, and (3) to study the association between maternal feeding practices and a child's well-being.

**METHODS**

A convenience sample of 412 mothers between 26 and 52 years old (mean [SD], 38.48 [4.45] years old) and their children (n = 412) (210 girls [51.9%] and 195 boys [48.1%]; no information obtained regarding sex for 7 children) between 6 and 10 years old (mean [SD], 7.81 [1.22] years old) were evaluated. The participants were recruited in public schools in the city of Braga, Portugal. The participation in the study was voluntary. Categorization of mothers' BMI was performed according to World Health Organization criteria: a BMI of less than 18.5 was used to classify mothers as underweight, a BMI of 18.5 or greater
Covert control behavior reflects a form of parental behavior that is not apparent to a child and involves the micromanagement of a child’s home and social environments. The final questionnaire had 38 items divided into 9 subscales (7 from Birch and 2 from Ogden questionnaires): perceived responsibility, perceived parental weight, perceived children’s weight, concern about children’s weight, restriction of intake of energy-dense snack foods, pressure to eat more food, monitoring, and overt and covert control. In this study, only the concern about children’s weight and the 5 scales that assess parental control attitudes and practices were used. These are (1) restriction (eg, “I have to be sure that my child does not eat too many sweets.”), (2) pressure to eat (eg, “My child should always eat all of the food on his/her plate.”), (3) monitoring (eg, “How much do you keep track of the sweets that your child eats?”), (4) overt control (eg, “How often do you encourage your child to eat more if you feel that they haven’t eaten enough that day or at mealtime?”), and (5) covert control (eg, “How often do you avoid going to cafes or restaurants that sell unhealthy foods with your children?”). All items were ranked with a 5-point Likert scale. In addition, participants were also evaluated with (2) the Child Behavior Checklist (CBCL 6-18)—the questionnaire consisted of 112 items; each item described a specific behavior. Those completing the form were asked to rate the frequency of each behavior on a 5-point Likert scale (0, not true; 1, somewhat or sometimes true; and 2, very true or often true). Scores were then summarized and converted to t scores on 8 different syndrome scales: anxious/depressed, withdrawn, somatic complaints, social problems, thought problems, attention problems, and aggressive behavior. These scores combined to yield an Internalizing Problems, Externalizing

### TABLE 1: Information Regarding Children and Mothers’ Characteristics

<table>
<thead>
<tr>
<th>Children’s Age, Mean (SD)</th>
<th>Mothers’ Age, Mean (SD), y</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.81 (1.22)</td>
<td>38.8 (4.45)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Female, n (%)</th>
<th>Male, n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>210 (51.9)</td>
<td>195 (48.1)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Underweight, n (%)</th>
<th>Normal Weight, n (%)</th>
<th>Overweight/Obese, n (%)</th>
<th>Underweight, n (%)</th>
<th>Normal Weight, n (%)</th>
<th>Overweight/Obese, n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>94 (22.8)</td>
<td>136 (33.3)</td>
<td>102 (22.4)</td>
<td>5 (1.2)</td>
<td>262 (63.9)</td>
<td>136 (32.9)</td>
</tr>
</tbody>
</table>

Eighty-eight mothers did not return the questionnaires; no information was obtained regarding sex for 7 children, and no information regarding height and/or weight was obtained for 80 children and 9 mothers. Weight and height were self-reported by mothers. A BMI of less than 18.5 was used to classify mothers as underweight, a BMI of 18.5 or greater and less than 24.99 was used to classify mothers as healthy weight, a BMI of 25 or greater and less than 29.99 was used to classify mothers as overweight, and a BMI of 30 or greater was used to classify mothers as obese. Age- and sex-specific BMI percentiles for children were also calculated. A BMI of less than 5 was used to classify children as underweight, a BMI of 5 or greater and less than the 85th percentile was used to classify children as healthy weight, a BMI greater than or equal to the 85th percentile was used to classify children as overweight, and a BMI greater than or equal to the 95th percentile was used to classify children as obese.
Problems, and Total Problems composite score. Therefore, the CBCL describes behavioral and emotional problems in children according to parents’ perception. Parents are requested to rate a child’s functioning in the past 6 months and are also requested to provide information about diseases, difficulties, what most concerns the informant in relation to that child, and what best describes the child. Finally, participants were then evaluated with the (3) Eating Disorders Examination Questionnaire (EDE-Q)\(^6\)—28 items were answered using a 7-point Likert scale that ranged from 0 (none) to 6 (everyday). The EDE-Q included 4 subscales that measured the severity of aspects related to pathological eating behaviors that have occurred in the past 28 days. These subscales included (1) restraint \((\alpha = .74)\), (2) eating concern \((\alpha = .74)\), (3) shape concern \((\alpha = .86)\), and (4) weight concern \((\alpha = .75)\). Greater scores in each dimension indicated a higher likelihood of disordered eating behaviors. A global score was calculated from the average of the four subscale scores \((\alpha = .92)\). The study met the concerns of the human subject committee. This research was presented as a study of mother-feeding control practices. Regarding the prediction of maternal covert control behavior, we applied a regression analysis with blocked entry procedures that controlled for children’s weight, the mothers’ concern about their children’s weight and then children’s anxiety/depression, and the mothers’ variables—food restriction and weight concern.

**RESULTS**

Mothers’ child-feeding practices were associated with a number of the child’s characteristics and emotional and behavioral problems. Mothers’ restriction practices were associated with a child’s higher BMI \((r = 0.12, P < .05)\). Mothers’ pressure to eat was associated with a child’s lower age \((r = -0.14, P < .01)\) and lower BMI \((r = -0.25, P < .001)\). Mothers’ use of monitoring was associated with a child’s lower scores on internalization \((r = -0.12, P < .05)\) and externalization \((r = 0.14, P < .01)\) CBCL scales (see Table 2). The mothers’ child-feeding practices were associated with a number of the mothers’ characteristics and her dysfunctional eating behaviors (see Table 3). A higher pressure to eat by mothers \((r = 0.01, P = .93)\) and overt control \((r = 0.05, P = .35)\) were associated with lower educational achievement. Younger mothers reported higher pressure to eat \((r = -0.08, P = .13)\) and more overt control over children’s eating \((r = -0.04, P = .49)\). Mothers with higher BMI also reported higher covert control over children’s eating \((r = 0.14, P < .01)\). Regarding dysfunctional eating behaviors, mothers’ EDE-Q restriction score was associated with her restricting child control practices \((r = 0.16, P < .001)\), and the covert control over a child’s eating was related to EDE-Q restriction \((r = 0.29, P < .001)\), EDE-Q eating concern \((r = 0.14, P < .01)\), EDE-Q shape concern \((r = 0.17, P < .001)\), and EDE-Q weight concern \((r = 0.19, P < .001)\).

In the first model, children’s BMI coefficients were not significant. In the second model, mothers who had a higher

**TABLE 2** Pearson and Point-Biserial Correlation Coefficients for Associations Between Maternal Child-Feeding Practices and Child Characteristics

<table>
<thead>
<tr>
<th>Maternal Child-Feeding Practice</th>
<th>Child’s Characteristics</th>
<th>Sex</th>
<th>Age</th>
<th>BMI</th>
<th>Internalization(a)</th>
<th>Externalization(a)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restriction</td>
<td>0.04</td>
<td>-0.07</td>
<td>0.12(^b)</td>
<td>-0.01</td>
<td>0.02</td>
<td>0.05</td>
<td></td>
</tr>
<tr>
<td>Pressure to eat</td>
<td>-0.08</td>
<td>-0.14(^c)</td>
<td>-0.25(^d)</td>
<td>0.09</td>
<td>0.06</td>
<td>0.06</td>
<td></td>
</tr>
<tr>
<td>Monitoring</td>
<td>-0.01</td>
<td>-0.25</td>
<td>-0.09</td>
<td>-0.12(^b)</td>
<td>-0.14(^c)</td>
<td>-0.10+</td>
<td></td>
</tr>
<tr>
<td>Overt control</td>
<td>-0.01</td>
<td>-0.04</td>
<td>0.02</td>
<td>-0.02</td>
<td>-0.01</td>
<td>-0.02</td>
<td></td>
</tr>
<tr>
<td>Covert control</td>
<td>0.04</td>
<td>-0.04</td>
<td>0.09</td>
<td>-0.01</td>
<td>0.03</td>
<td>0.01</td>
<td></td>
</tr>
</tbody>
</table>

Abbreviation: BMI, body mass index.

\(^a\)Internalization and externalization are subscales of the Child Behavior Checklist.

\(^b\)\(P < .05\).

\(^c\)\(P < .01\).

\(^d\)\(P < .001\).
TABLE 3  Pearson and Point-Biserial Correlation Coefficients for Associations Between Maternal Child-Feeding Practices and Maternal Characteristics

<table>
<thead>
<tr>
<th>Maternal Child-Feeding Practice</th>
<th>Maternal Characteristics</th>
<th>Scholarship</th>
<th>Age</th>
<th>BMI</th>
<th>Restrictiona</th>
<th>Eating Concerna</th>
<th>Shape Concerna</th>
<th>Weight Concerna</th>
<th>EDE-Qb</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restriction</td>
<td></td>
<td>0.01</td>
<td>−0.08</td>
<td>−0.01</td>
<td>0.16c</td>
<td>0.04</td>
<td>0.06</td>
<td>0.06</td>
<td>0.09</td>
<td></td>
</tr>
<tr>
<td>Pressure to eat</td>
<td></td>
<td>−0.20c</td>
<td>−0.12d</td>
<td>0.06</td>
<td>−0.02</td>
<td>0.01</td>
<td>0.02</td>
<td>0.01</td>
<td>0.02</td>
<td></td>
</tr>
<tr>
<td>Monitoring</td>
<td></td>
<td>0.10</td>
<td>−0.07</td>
<td>−0.02</td>
<td>0.05</td>
<td>−0.08</td>
<td>−0.02</td>
<td>−0.04</td>
<td>−0.01</td>
<td></td>
</tr>
<tr>
<td>Overt control</td>
<td></td>
<td>−0.12d</td>
<td>−0.17c</td>
<td>0.05</td>
<td>0.06</td>
<td>−0.05</td>
<td>−0.08</td>
<td>−0.07</td>
<td>−0.04</td>
<td></td>
</tr>
<tr>
<td>Covert control</td>
<td></td>
<td>0.05</td>
<td>−0.04</td>
<td>0.14e</td>
<td>0.29c</td>
<td>0.14e</td>
<td>0.17c</td>
<td>0.19c</td>
<td>0.23c</td>
<td></td>
</tr>
</tbody>
</table>

Abbreviation: BMI, body mass index.

aRestriction and eating, shape, and weight concern are subscales of EDE-Q.
bTotal score of Eating Disorders Examination Questionnaire.
cP < .001.
dP < .05.
eP < .01.

concern with their children’s weight reported higher covert control behavior over children’s feeding practices. In the third model, children’s anxiety and depression regression coefficients were not significant. The inclusion of the mothers’ variables in the final model resulted in a significant model accounting for 11.7% of the final variance in the mothers’ covert control behavior over their children’s feeding practices. In this case, higher covert control behavior by mothers over children’s feeding practices was predicted by higher food restriction by mothers (see Table 4).

DISCUSSION

This study aimed to evaluate the associations between maternal feeding practices and some mother and child

TABLE 4  Regression Model Results for Maternal and Child Characteristics Explaining Maternal Covert Control Child-Feeding Practices

<table>
<thead>
<tr>
<th>Model</th>
<th>R² (adj R²)</th>
<th>F</th>
<th>β</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model 1</td>
<td>0.00 (-0.00)</td>
<td>F₁,₂₇₄ = 1.24</td>
<td>0.07</td>
<td>1.11</td>
</tr>
<tr>
<td>Children’s BMI</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Model 2</td>
<td>0.04 (0.03)</td>
<td>F₂,₂₇₃ = 5.40a</td>
<td>0.20</td>
<td>3.08a</td>
</tr>
<tr>
<td>Mothers’ concern about children weight</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Model 3</td>
<td>0.05 (0.04)</td>
<td>F₃,₂₇₂ = 4.44a</td>
<td>0.09</td>
<td>1.57</td>
</tr>
<tr>
<td>Children’s anxiety/depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Model 4</td>
<td>0.13 (0.12)</td>
<td>F₅,₂₇₀ = 8.30b</td>
<td>0.29</td>
<td>4.49b</td>
</tr>
<tr>
<td>Mothers’ food restriction</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mothers’ weight concern</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Abbreviation: adj, adjusted; BMI, body mass index.

aP < .01.
bP < .001.
variables. In addition, it also aimed to highlight predictors of mothers' covert control feeding practices. Our study is unique in its focus on the relationship between maternal feeding practices and children's well-being. As we noted in the Introduction, previous studies evaluated parental feeding practices and their relationship with numerous variables such as parenting styles and weight-related variables of mothers and children. As far as we know, this is the first study to evaluate the relationship between maternal feeding control practices and children's well-being when considering internalization and externalization problems. However, the feeding practices that have received more attention are pressure to eat and restriction. Few studies investigated other forms of feeding practices such as mothers' overt and covert control.

Our findings suggest that the type of control used by mothers is related to both maternal and child factors. Consistent with other studies, mothers reported using more restrictive feeding practices when children were heavier. Similarly, mothers also reported higher pressure to eat when children had a lower weight. Wright and colleagues also found that tactics to encourage children to eat were more commonly used by mothers who reported children's eating problems, hypothesizing that eating problems probably trigger greater parental concern in children who were already relatively small. Primary care clinicians should then consider children weight status and maternal eating and weight concerns when working with families and feeding-related issues.

Alternatively, our results showed that a mother's feeding monitoring was related to a child's lower level of internalization and externalization symptoms. These data may be explained by the fact that, somehow, levels of moderate monitoring can be adaptive, and monitoring feeding practices acknowledges a child's needs and demands for food; responses to these needs and demands may be related to higher levels of psychological well-being. In fact, Birch and Fisher had already speculated that overcontrolling child-feeding practices may contribute to the inhibition of children's development of self-control over eating and self-regulation. However, little is known about the relationship between well-being and parental feeding practices. Future studies should continue to examine the relationship between children's well-being and parents' child-feeding practices. Nevertheless, our study supports the role of maternal feeding monitoring as potentially adaptive. If we consider that emotional and behavioral problems have been found to be associated with the presence of feeding problems in preschool and school-aged children, our results suggest that maternal monitoring can be related to children's well-being. All other maternal control feeding practices were not related to the evaluated children's variables. With the exception of mothers' restriction control practices and in accordance with previous findings, children's BMI was not correlated with any parental feeding practices in this study.

Regarding the mothers' variables, being younger and having a lower level of education were associated with greater pressure to eat and overt control of children's eating. Haycraft and Blisset did not support the association between mothers' age and child-feeding control practices. However, in their study, the children were younger. Future research should investigate this association with older children. On the other hand, in a recent study, Machado et al found that picky eating was more common in children from lower-income families with younger parents compared with the parents of nonpicky eaters. We can speculate about the role of both sociodemographic maternal characteristics and the used feeding practices hypothesizing that pressure to eat and overt control may be even more prevalent if younger mothers consider their children as having poor appetite, fussiness, or picky eating. Moreover, mothers having a low income and/or a lower level of education may experience feeding practices as being more demanding in comparison with other mothers.

In accordance with previous findings, mothers' restrictive child-feeding practices were related to mothers' highest restrictions. Maternal restrictive feeding practices seem to be related to the mothers' personal eating concerns and food issues. In the same way, mothers' covert control practices were related to their higher restrictions and food, shape, and weight concerns. It is noteworthy that mothers who use restrictive and covert control feeding practices may be particularly invested in their own weight and eating issues. This explanation was corroborated with the regression analysis results. Therefore, mothers' covert control was predicted by their concerns about their children's weight and their own restrictive eating behavior. Ogden and colleagues defined covert control as the control that involves limiting a child's intake of unhealthy foods in a way that is undetected by the child but that still results in restriction. Contrary to Ogden and colleagues' findings, we did not find that the children's BMI significantly predicted the use of covert control. Instead, mothers' concern with their children's weight predicted the use of covert feeding control. This may suggest that mothers' covert feeding control is not related to the child's weight per se and may reflect the mothers' habits of managing their own diet and weight/eating issues. Covert control may be a form of management used by parents as a reaction to the perception that a child is becoming overweight, particularly in a family where being thin is considered the norm. On the
other hand, covert control could be used as a preemptive management tool if, for instance, the family has a history of obesity.

Regarding children’s internalization and externalization problems and covert control, our results may suggest that covert control may represent a protective factor in children’s well-being. In fact, covert control defined as “controlling a child’s food intake in a way that cannot be detected by the child” was in previous research\(^{29}\) associated with lower BMI and increased fruit intake in preschoolers. This may imply that covert control may have a protective influence on child’s weight status, eating habits, and, according to our results, general well-being.

Some possible limitations of this research should be noted. First, all data were collected through maternal reporting, so we do not have an independent description of the children’s behavior and about paternal impressions. Second, the current study used a convenience sample. Third, the retrospective cross-sectional nature of the study prevents conclusions about cause and effect. Future research would benefit from longitudinal studies that examine the temporal relationship between the variables and move toward a deeper understanding of the relationship between maternal child-feeding practices and maternal and child characteristics.

This study highlights the association between some maternal feeding practices and some maternal eating and weight-related variables. Namely, more restrictive feeding practices were associated to heavier children and, in turn, higher pressure to eat to thinner children. Curiously, restrictive feeding practices were also associated to mothers’ own restriction behavior and covert control feeding practices. Moreover, covert control was predicted by mothers’ concern about child’s weight and their own eating restrictive behavior. On the other hand, pressure to eat and overt control were also more associated with younger mothers and lower education. Therefore, clinicians may enhance sensitivity in younger mothers and mothers with lower education to these feeding behaviors and related consequences. In the end, feeding monitoring was found to be related to lower levels of internalizing and externalizing problems.

These findings raise some concern if we consider that these maternal feeding practices can model eating behavior and disrupt children’s self-regulation of food intake or may be adaptive as the association found between maternal feeding monitoring and children’s lower levels of internalizing and externalizing problems may demonstrate. Future research using longitudinal designs should evaluate not only developmental pathways of eating behavior and the impact of the mother but also other influence of other family/household members. Clinicians must become more aware of the potential impact of maternal feeding practices on a child’s eating behavior. Based on our research, we propose a tripartite model that considers 3 important clusters of factors: ones that are elicited by the child’s characteristics, ones that are related to maternal sociodemographic characteristics, and ones that are embedded in the mothers’ own eating and weight concerns.

**REFERENCES**

18. Brann LS, Skinner JD. More controlling child-feeding practices are found among parents of boys with an average body mass index

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