



Research report

Maternal psychosocial predictors of controlling parental feeding styles and practices

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ABSTRACT

The aim of the current study was to explore the relative contribution of parental depression, anxiety and stress and parenting satisfaction and efficacy to the explanation of variance in controlling parental feeding styles and practices. The sample comprised 124 mothers ($M = 36.80$ years, $SD = 4.62$ years) who reported on both themselves and a selected child (59 male, 65 female; $M = 6.46$ years, $SD = 0.95$ years). Mothers completed several questionnaires examining demographic information, parental feeding styles, parental feeding practices, parental depression, anxiety and stress and parenting satisfaction and efficacy. Parenting satisfaction contributed significantly to the prediction of the parental feeding practice pressure to eat. Parenting satisfaction and parental anxiety contributed significantly to the prediction of the parental feeding practice restriction. The results of this study provide important insight into maternal characteristics associated with the use of controlling parental feeding styles and practices.

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Introduction

Parents play an important role in the development of children's eating habits through the parental feeding styles and practices they adopt (Ventura & Birch, 2008). A number of controlling parental feeding styles and practices have been linked to unhealthy eating styles, diet and weight in children (Clark, Goyder, Bissell, Blank, & Peters, 2007; Ventura & Birch, 2008). Identifying parental characteristics associated with the use of controlling parental feeding styles and practices will assist in the development of interventions to modify them.

Parental feeding styles are the overarching feeding approaches a parent adopts consistently across all parental feeding situations (Ventura & Birch, 2008). Parental feeding practices are the specific strategies that parents use in an attempt to maintain or modify their child's eating style and diet; these practices may vary between contexts (Ventura & Birch, 2008). For example, a mother may use different parental feeding practices for each of her

children, or change practices as her child grows while retaining the same general parental feeding style over time and situations.

Controlling parental feeding styles and practices have been linked with a range of unhealthy eating styles (e.g. eating in the absence of hunger; Fisher & Birch, 2000; Fisher & Birch, 2002), dietary patterns (e.g. decreased vegetable consumption; Gallo-way, Fiorito, Lee, & Birch, 2005; Patrick, Nicklas, Hughes, & Morales, 2005) and weight in children (Francis, Hofer, & Birch, 2001; Lee, Mitchell, Smiciklas-Wright, & Birch, 2001). While the majority of studies indicate that controlling parental feeding styles are associated with negative child outcomes, some studies have reported no relationship (Clark et al., 2007; Montgomery, Jackson, Kelly, & Reilly, 2006) and others have reported that the parental feeding practice restriction is associated with lower weight in children (Farrow & Blissett, 2008). More recently, it has been suggested that control itself does not lead to poor diet outcomes, rather it is the method of control that determines outcomes (Brown, Ogden, Vögele, & Gibson, 2008; Ogden, Reynolds, & Smith, 2006). For instance, covert control has been linked with the consumption of fewer unhealthy snacks, increased fruit and vegetable consumption and lower levels of food neophobia in children while overt control has been linked with the consumption of more healthy snacks and increased fruit and vegetable consumption in children (Brown et al., 2008; Ogden et al., 2006).

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A number of parental factors are associated with parental feeding practices. Parental perception of a child's weight (Birch et al., 2001) and concern about child weight (Francis et al., 2001) are associated with the use of controlling parental feeding practices. Parental psychological health has also been linked to controlling parental feeding styles and practices. For instance, higher levels of psychological distress (Blissett & Farrow, 2007), maternal anxious psychopathology (Farrow & Blissett, 2005) and parental depression, anxiety and stress (Hurley, Black, Papas, & Caufield, 2008) have been shown to be associated with restriction in infants. One study failed to demonstrate an association between maternal depression and the use of restriction or pressure to eat in infants (Farrow & Blissett, 2005). However, in one of the only studies looking at children aged 5 years, higher levels of parental depression was linked with restriction and pressure to eat (Francis et al., 2001).

These findings are generally consistent with previous research linking parental psychological health with ineffective parent behaviours not specific to the feeding context. Parental psychological health has been linked to hostile and coercive parenting behaviours (Lovejoy, Graczyk, O'Hare, & Neuman, 2000) and higher levels of parental control (van der Bruggen, Stams, & Bögels, 2008). Low levels of parenting efficacy (Hill & Bush, 2001) and parenting satisfaction (Simons, Beaman, Conger, & Chao, 1993) are also associated with the use of ineffective and controlling parenting practices in the general parenting literature. These findings suggest that parenting satisfaction and efficacy may be important in parental feeding however these factors have received limited research in the feeding context.

Given the potential negative child outcomes associated with controlling parental feeding styles and practices, and the recent increase in interventions to improve parental feeding styles and practices, research is needed to identify parental factors related to the use of such methods. The aim of the current study was to explore the relative contribution of parental depression, anxiety and stress and parenting satisfaction and efficacy to the explanation of variance in controlling parental feeding styles and practices.

Methods

Participants

The sample comprised mothers ($N = 124$) recruited from a larger study investigating children's lunchbox contents (Miles, Brennan, Mitchell, & Matthews, 2009). To partake in the study, participants were required to be over the age of 18 years, have a child attending primary school and have an understanding of spoken and written English. One hundred and seventy-six questionnaire packages were distributed and 124 were returned (response rate 70.5%). Mothers ages ranged from 26 to 47 years ($M = 36.80$ years, $SD = 4.62$ years). The majority of mothers were of Australian ethnicity (89%) and just over a third (37%) had attained a tertiary qualification. Mothers providing height and weight information were classified as underweight (2%), healthy weight (53%), overweight (33%) and obese (12%). BMI category could not be calculated for 6% of mothers due to non-reporting of height. For the child related variables, mothers were asked to report on one of their children who were in one of the first 3 years of school. The child sample consisted of 59 male and 65 female children aged 5–8 years ($M = 6.46$ years, $SD = 0.95$ years). BMI categories could not be calculated for 26% of children due to non-reporting of height (23%) and weight (5%). Of those for whom BMI categories could be calculated, the International Obesity Task Force criteria (Cole, Bellizzi, Flegal, & Dietz, 2000; Cole, Flegal, Nicholls, & Jackson, 2007) were used to categorise children as underweight (18%), healthy weight (64%), overweight (12.4%) or obese (5.6%).

Compared to recent National Statistics (Commonwealth Scientific Industrial Research Organisation, 2008), the category *underweight* is overrepresented and the category *healthy weight* is underrepresented in the current sample.

Materials

Participants completed a questionnaire package which included the following measures:

Demographic Background Data Questionnaire. This questionnaire was based on the demographic survey used by the Parenting Research Centre and consists of 32 items measuring parental and child demographic information such as parental age, gender, country of birth, height, weight, relationship to the child (e.g. parent, step-parent), highest level of education, current employment status and child's age, gender, height and weight.

The Caregiver's Feeding Styles Questionnaire (CFSQ; Hughes, Power, Fisher, Mueller, & Nicklas, 2005). The CFSQ is a 24-item questionnaire which assesses parental feeding styles; two feeding styles were included in this study, authoritarian parental feeding style (characterised by a range of controlling and unresponsive behaviours parents adopt in the feeding context such as punishing, coercion and rejection; e.g. "How often do you physically struggle with your child to get him/her to eat?", $\alpha = .86$) and authoritative parental feeding style (characterised by parental involvement, reasoning and structure; e.g. "How often do you allow your child to choose appropriate foods?", $\alpha = .71$; Hughes et al., 2005). Items were scored according to criteria presented by Patrick et al. (2005) whereby participants receive a separate score for authoritarian and authoritative feeding style. Each item is rated along a 5-point Likert scale ranging from '1' = 'Never' to '5' = 'Always' and higher scores indicate higher levels of each subscale.

The Child Feeding Questionnaire (CFQ; Birch et al., 2001). The CFQ is a 31-item measure assessing parents' attitudes, beliefs and practices related to parental feeding. The questionnaire consists of 7 subscales; two controlling parental feeding practices subscales were used in this study, pressure to eat, (the degree to which a parent pressures a child to increase their consumption of foods; e.g. "I have to be especially careful my child eats enough", $\alpha = .70$) and restriction (the degree to which a parent limits a child's access to foods; e.g. "I have to be sure that my child does not eat too many sweets [candy, ice cream, cake or pastries]", $\alpha = .73$; Birch et al., 2001). Each item is rated along a 5-point Likert scale with higher scores indicating higher levels of each subscale.

The Overt/Covert Control Scale (Ogden et al., 2006). The Overt/Covert Control Scale consists of 10 items measuring parents' levels of overt and covert control over their child's eating behaviour. The questionnaire consists of 2 subscales; overt control (limiting consumption of 'unhealthy' foods in a manner than can be perceived by the child; e.g. "How often are you firm about what your child should eat?", $\alpha = .71$) and covert control (limiting the consumption of 'unhealthy' foods in such a way that the child is unaware of the restriction; e.g. "How often do you avoid buying sweets and crisps and bringing them into the house?", $\alpha = .79$). Each item is rated along a 5-point Likert scale ranging from '1' = 'Never' to '5' = 'Always'. Participants receive a separate score for each of the subscales; higher scores indicate higher levels of overt and covert control.

Parenting Sense of Competence Scale (PSOC; Johnston & Mash, 1989). The PSOC is a 16-item measure of parenting self-esteem. The measure consists of two subscales; efficacy ($\alpha = .76$) and satisfaction ($\alpha = .75$; Johnston & Mash, 1989). Each item is rated along a 6-point Likert scale with responses ranging from 'SA' = 'Strongly agree' to 'SD' = 'Strongly disagree'. Participants receive a separate score for each of the subscales; higher scores indicate higher levels of efficacy and satisfaction.

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