

THE INFLUENCE OF PARENTING PRACTICES ON FEEDING PROBLEMS IN PRESCHOOLERS

INFLUENCIA DE LAS PRÁCTICAS EDUCATIVAS EN LOS PROBLEMAS ALIMENTARIOS EN PREESCOLARES

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Abstract

The aim of the study is to estimate the prevalence of feeding problems during the preschool period and to explore the associations of feeding related behaviors with parenting practices. Participants were a large community sample of $N = 622$ children longitudinally assessed yearly at ages 3, 4 and 5 years-old through diagnostic interview and questionnaires reported by

parents. The prevalence of children who met DSM-IV criteria for feeding disorder during the follow-up was 1.6%, the amount of children who presented feeding disorder symptoms was 33.3%, those with clinical impairment due to these symptoms were 25.7% and 11.6% reported seek for professional help related to feeding problems. Logistic regressions adjusted to children's sex and other DSM-IV diagnoses different to feeding disorder showed that the dimensions of parenting more strongly related to feeding related behaviors and

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impairment due to feeding problems were poor monitoring, inconsistence practices, corporal punishment, low norms and low autonomy. Although the prevalence of preschool children who met DSM-IV criteria for feeding disorder was relatively low, the presence of feeding related behaviors (symptoms, impairment and consultation) was common during this developmental period. Parenting practices are associated to the presence of these behaviors, and so they must be considered into the prevention and intervention programs.

Keywords: feeding problems; parenting; preschool.

Resumen

El objetivo del estudio es estimar la prevalencia de problemas relacionados con la alimentación durante el período preescolar y explorar las asociaciones de conductas relacionadas con la alimentación con las prácticas. Se estudió una amplia muestra comunitaria de niños ($N = 622$), que fue evaluada anualmente de forma longitudinal a la edad de 3, 4 y 5 años, mediante entrevistas diagnósticas y cuestionarios contestados por sus padres. La prevalencia de niños que cumplió criterios diagnósticos DSM-IV para recibir un diagnóstico de Trastornos de la Alimentación durante el seguimiento furede 1.6%, la cantidad de niños que presentó síntomas del trastorno llegó al 33.3%, los que presentaron deterioro clínico debido a estos síntomas fueron el 25.7% y hasta un 11.6% de las familias buscó ayuda profesional relacionada con los problemas relacionados con la alimentación. Los datos, analizados mediante regresiones logísticas ajustadas por el sexo de los niños y la presencia de otros diagnósticos DSM-IV, mostraron que las dimensiones de estilo parental más estrechamente relacionadas con los problemas y el deterioro relacionados con la alimentación fueron la pobre supervisión, las prácticas educativas inconsistentes, el castigo corporal, la baja presencia de normas y la escasa autonomía. Aunque la prevalencia de niños preescolares que cumplían criterios diagnósticos para el Trastorno de alimentación fue relativamente baja, la presencia de problemas relacionados con la alimentación (síntomas, deterioro funcional y consulta) resultó

ser común durante esta etapa evolutiva. Las prácticas parentales están asociadas a la presencia de estos problemas, y por tanto deberían ser consideradas en los programas de prevención e intervención.

Palabras clave: pautas educativas; preescolares.

Introduction

Feeding problems are common among young children. Around 25-45% of normally developing children are reported to experience a feeding problem during childhood (Bryant-Waugh, Markham, Kreipe, & Walsh, 2010). Based on the Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR; APA 2000) criteria, about 1-5% children are diagnosed with a Feeding Disorder of Infancy or Early Childhood, FD (Ostberg & Hagelin, 2011). Parents are concerned that their children are displaying behaviors such as selective eating, food refusal, food neophobia, picky eating, fussy eating, eating slowly, being less interested in food, having a small appetite, infantile anorexia, and sensory food aversion (Carruth, Ziegler, Gordon, & Barr, 2004; Marchi & Cohen, 1990; Mitchell, Farrow, Haycraft, & Meyer, 2013; Reau, Senturia, Lebailly, & Christoffel, 1996; Sanders, Patel, Le Grice, & Sheperd, 1993). Ostberg and Hagelin (2011) conducted a 6-year follow-up study and found that picky eating was the most frequent problem in children, followed by irritation or a bad temper at meal times, food refusal, and child's eating or feeding habits being a problem for the family. Additionally, Equit et al. (2013) found that prevalence rates for 'eating only a narrow range of food' (23.2%) and for 'unwillingness to try new foods' (25.9%) were comparable with rates of picky eating (20-50%) and even higher for 'avoidance of certain foods' (53%). The presence of these feeding problems can be detected from early childhood to mid adolescence. A longitudinal study by Ammaniti, Lucarelli, Cimino, D'Olimpio, and Chattoor (2012) found homotypical continuity in 50-80% of the children with early food refusal. The continuity of these behaviors can lead to several negative consequences including low weight gain (Marchi & Cohen, 1990; Wright & Birks, 2000), nutrient deficiency and poor dietary variety (Galloway, Fiorito,

Lee, & Birch, 2005), growth faltering, cognitive and developmental delays (Chatoor, Egan, Geston, Menveille, & O'Donnell, 1988; Wright & Birks, 2000), problematic and stressful mealtimes (Sanders et al., 1993), a poor diet in adulthood (e.g., Craigie, Lake, Kelly, Adamson, & Mathers, 2011), and the development of eating disorders in the future (Kotler, Cohen, Davies, Pine, & Walsh, 2001; Marchi & Cohen, 1990). In addition, a child's problematic feeding behavior can be problematic for parents. Previous research has shown that mothers of children with feeding problems often have higher levels of depression and anxiety (Blissett, Meyer, & Haycraft, 2007; Chatoor, Ganiban, Colin, Plummer, & Harmon, 1998; Coulthard & Harris, 2003; Duniz et al., 1996; Lindberg, Bohlin, Hagekull, & Palmerus, 1996; Whelan & Cooper, 2000), emotional distress (Budd et al., 1992), parenting stress (Singer, Song, Hill, & Jaffe, 1990; Spender et al., 1996), or poorer problem-solving abilities (Ünlü, Aras, Guvenir, Buyukgebiz, & Bekem, 2006). So, feeding problems at an early age can cause major problems in not only the child's life, but the parent's life as well.

In order to prevent feeding problems and improve children's eating behavior, a thorough understanding of early life risk factors is necessary. One early life risk factor that can be observed is parent's parenting practices. Parenting practices are the behavioral strategies that parents use to socialize their children (Darling & Steinberg, 1993; Ventura & Birch, 2008). Many studies on general parenting behaviors have found that authoritative parenting (high demandingness and high responsiveness, parent is firm, but not rigid, willing to make an exception when the situation warrants) is associated with the most positive child outcomes (Baumrind, 1996; Darling & Steinberg, 1993; Maccoby & Martin, 1983). Research has shown that children of authoritative parents have greater independence, self-control, self-efficacy, self-discipline, and more emotional maturity, while children from authoritarian and permissive parents are less likely to develop emotional maturity, behavioral inhibition, and self-regulation (Hubbs-Tait, Kennedy, Page, Topham, & Harrist, 2008; Topham et al., 2011). Similarly, in relation to feeding, the authoritative style of providing rules in a positive context is associated with the development of the healthiest eating habits (Ventura

& Birch, 2008). Only a few studies have looked at parenting practices and feeding problems, while a majority of studies have looked specifically at feeding practices (Blissett, Meyer, & Haycraft, 2006; Haycraft & Blissett, 2012; Morrison, Power, Nicklas, & Hughes, 2013; Wehrly, Bonilla, Perez, & Liew, 2014). Overall, there is a lack of research regarding general parenting practices and feeding problems and for that reason, it is crucial to continue conducting studies that look at these variables together in order to reach accurate conclusions and development of preventative treatments or interventions. Because parenting practices can potentially act as an early life risk factor for feeding problems, this study observed both parenting practices and feeding problems in a sample of preschoolers in Barcelona, Spain. This study aims to investigate the prevalence of FD and feeding problems in a sample of preschoolers and its association with parenting practices and its clinical related behaviour.

Method

Participants

The data analyzed in this study correspond to a longitudinal study of behavioral problems along preschool period (Ezpeleta, De la Osa, & Doménech, 2014). A total of 2,283 children from 54 schools (25.9% semi-public and 74.1% public) were randomly selected from the census of preschoolers of 3 years-old in Barcelona (Spain) from the 2009-2010 academic year (N = 13,578). A double phase design was utilized in order to have a final sample with enough prevalence of disruptive psychopathology. In the first phase of the sampling, 1,341 families (58.7%) agreed to participate while 930 (41.0%) refused and 12 (0.5%) were excluded due to the presence of intellectual disability or pervasive developmental disorder in the children. Considering the 1,341 families who agreed to participate, 33.6% were into the high socioeconomic status level, 43.1% into mean levels, and 23.3% into low levels. Children were screened with the Spanish version (Ezpeleta, Granero, de la Osa, Penelo, & Domènech, 2013) of The Strengths and Difficulties Questionnaire-Parent (SDQ; Goodman, 2001) and two

groups were comprised according to the screening criterion score: (a) positive screen, for children who met a raw score above 4 in the SDQ-conduct scale or at least one symptom of the oppositional defiant disorder list, and (b) negative screen, for children who did not meet the previous criterion. A random sample of 30% of children into negative screen group was selected (205 children, 105 boys and 100 girls) and all the children into the positive screen group (417, 206 boys and 211 girls) were included in the final sample who was followed during the next two years. So, the final sample included N = 622 children who were yearly assessed at ages 3 years-old, 4 years-old (N = 604 remained into the follow-up), and 5 years-old (N = 574 remained). Table 1 contains the demographic and clinical characteristics of the sample at baseline (the first assessment and beginning of follow-up, age 3).

Instruments

The Diagnostic Interview of Children and Adolescents for Parents of Preschool Children (DICA-PPC; Ezpeleta, De la Osa, Granero, Domènec, & Reich, 2011) is a semi-structured interview designed for

children between 3 and 7 years of age, based on the Diagnostic Interview for Children and Adolescents-IV, DICA-IV (Reich, 2000). The DICA-PPC is a computerized instrument that assesses children's psychopathology according to the DSM-IV-TR criteria (American Psychiatric Association, 2000). Parents were the informants. The DICA-PPC includes the most frequent DSM-IV-TR disorders in childhood. After the assessment of the symptoms list, parents are asked about child's impairment due to each diagnose (how symptoms or pathology are affecting the child's daily life at school, with family, and peers), consultation (seek of professional help, a professional-clinical psychologist, psychiatrist, school psychologist or pediatrician). DICA-PPC was used to assess the feeding disorder measures of this study (feeding symptoms, impairment and consultation) and the presence of other comorbid disorders different to feeding.

The Alabama Parenting Questionnaire-Preschool Revision (APQ-Pr) is the result of the Spanish version of the original Alabama Parenting Questionnaire (APQ; Frick, 1991; Shelton, Frick, & Wootton, 1996). Parents answer a total of 50 items rated on a 5-point-likert-scale (from 1 = never to 5 = always) about parenting style, which are structured in seven scales/dimensions: (a) five

Table 1

Demographic and clinical characteristics of the sample at age 3 years-old (N=622).

Child's age (mean; standard deviation)	3.77 (0.33)
Child's sex (male) (n; %)	310 (49.8%)
Ethnic group(n; %)	Caucasian (white) 554 (89.1%) Hispanic 40 (6.4%) Other 28 (4.5%)
Socioeconomic status (n; %)	High 205 (33.0%) Mean-High 195 (31.4%) Mean 88 (14.2%) Mean-low 99 (15.9%) Low 35 (5.6%)
DSM-IV Disorders (n; weighted prevalence)	
Attention Deficit Hyperactivity Disorder	34 (3.7%)
Oppositional Defiant Disorder	61 (6.9%)
Conduct Disorder	10 (1.4%)
Depressive Disorder	4 (0.4%)
Separation Disorder	18 (2.2%)
Specific Phobia	27 (3.6%)
Feeding Disorder	10 (1.2%)

Table 2

Distribution of diagnosis of feeding measures during the preschool period: count and weighted prevalences

	Age 3 (N=622)	Age 4 (N=604)	Age 5 (N=574)	Age 3-4-5 (N=574)
DSM-IV FD Diagnosis	10 1.17%	5 0.70%	6 0.85%	14 1.56%
Presence of any DSM-IV FD symptom	141 20.25%	103 15.59%	83 12.87%	220 33.30%
Failure to gain weight	13 7.21%	6 6.20%	6 6.04%	18 6.43%
Limited repertoire of foods	64 8.92%	44 6.20%	29 4.93%	103 14.64%
Eats favorite foods without difficulty	43 6.11%	30 4.45%	21 3.77%	75 10.95%
Problematic eating during meal times	106 14.36%	86 13.35%	67 10.55%	183 26.83%
Growth problems due to eating problems	13 1.46%	6 0.97%	6 0.78%	18 2.14%
Problems when introducing food	38 5.43%	11 1.46%	8 0.78%	50 6.60%
Impairment due to FD	105 14.83%	76 11.81%	57 8.81%	171 25.66%
Consultation (seek of professional help due to FD)	62 8.34%	36 5.04%	21 2.62%	86 11.64%

Note. FD: feeding disorder. Age 3-4-5 measures the presence of the feeding measure at child's age 3 or 4 or 5 years-old.

scales derived from the original APQ (involvement, positive parenting, poor monitoring/supervision, inconsistent discipline and corporal punishment), and (b) two additional scales (autonomy and norms). from Evaluation des Pratiques Educatives Parentales (EPEP; (Roskam & Meunier 2009). Psychometric properties were adequate (De la Osa, Granero, Penelo, Domènec, & Ezpeleta, 2013).

Statistical Analysis

It was carried out with SPSS 20 for Windows. All the analyses were weighted due to the multi-sample design, assigning to each child a weight equal to the inverse of the probability of selection in the screening phase of the longitudinal research. Logistic regressions, adjusted by the covariates children's sex and other comorbidities different to FD, valued the association between parenting practices (APQ-Pr scales) and FD related variables (the presence of the DSM FD disorder, the presence of any FD symptom, impairment due to FD and consultation due to FD). The ENTER-procedure was used to simultaneously include all the APQ-Pr scales (and the covariates). Hosmer-Lemeshow test valued goodness-of-fit (adequate fitting was considered for $p > .05$), discriminative capacity was assessed with the area under the ROC curve (AUC, considering poor discrimination AUC $< .60$, moderate $.60 < AUC < .70$ and good AUC $> .70$) and the global predictive capacity with the Nagelkerke's pseudo-R² coefficient.

Procedure

The Ethics Review Committee of the authors' institution approved the project. All parents with children who attended to P3-grade at the schools included in the longitudinal research were invited to answer the SDQ. Families who agreed to participate were required to submit parental written consent. All interviewers were thoroughly trained in the use of the instruments of the study and interviews were blinded to the screening groups. All interviews were audio-recorded and supervised during all the follow-up. Data analyzed in this work correspond to the APQ-Pr measured at age 3 years-old and the DICA-PPY at ages 3-4-5 years-old.

Results

Presence of feeding problems during preschool period

Table 2 includes the prevalences for the DSM FD, the FD symptoms, the impairment due to FD and the consultation for FD. The prevalence during the preschool period (defined as the presence of these feeding related behaviors at ages 3 or 4 or 5 years old) was 1.6% for the DSM FD diagnosis, 33.3% for the presence of FD

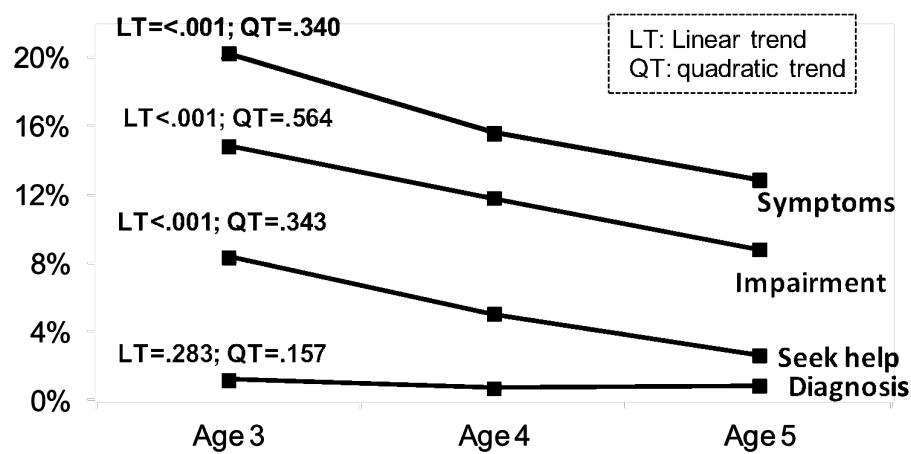


Figure 1. Evolution of feeding disorders related behaviors during the preschool period.

symptoms, 25.7% for the impairment due to FD, and 11.6% for the consultation due to FD.

Considering the evolution during ages 3 to 5 (Table 2 and Figure 1), feeding problems are more prevalent at 3 years old and tended to decrease at ages 4 and 5 years-old. The assessment of linear trends achieved statistically significant for the presence of symptoms, impairment, and consultation (prevalence tended to decrease as age increases). Quadratic trends were not statistically significant, showing that decreases in prevalences between 3 and 4 years-old are statistically equal to decreases between ages 4 and 5 years-old. The diagnosis of DSM-IV

FD did not achieve linear or quadratic trends, indicating that prevalence for this disorder was statistically constant during the follow-up.

Table 3 contains the results of the logistic regressions exploring the cross-sectional association between parenting practices scores and FD measures at 3 years of age, adjusted to children's sex and other comorbid disorder. Results indicated that at this age, high scores in the APQ-inconsistency scale were statistically predictive of the presence of FD symptoms and impairment.

Table 3

Cross-sectional association between parenting practice scores (APQ-Pr scales) and feeding measures at age 3 (N=622).

Parenting style score	DSM diagnosis of FD			Presence of DSM FD symptoms			Impairment due to FD			Consultation due to FD		
	p	OR	95% CI	p	OR	95% CI	p	OR	95% CI	p	OR	95% CI
Positive	.211	1.295	0.864 1.940	.241	1.063	0.960 1.177	.231	1.074	0.955 1.208	.731	1.025	0.889 1.183
Involvement	.069	0.812	0.648 1.016	.965	1.001	0.951 1.054	.925	1.003	0.945 1.064	.364	0.966	0.897 1.041
Poor monitoring	.846	0.965	0.671 1.386	.467	1.039	0.937 1.152	.861	0.990	0.880 1.112	.177	1.103	0.957 1.272
Corporal punishment	.605	0.835	0.421 1.656	.322	1.092	0.917 1.302	.156	1.149	0.948 1.391	.307	1.129	0.895 1.423
Inconsistent discipline	.971	1.006	0.733 1.381	.010	1.134	1.031 1.247	.010	1.150	1.034 1.279	.466	1.050	0.920 1.199
Norms	.129	0.841	0.673 1.051	.168	0.941	0.864 1.026	.169	0.935	0.850 1.029	.381	0.948	0.842 1.068
Autonomy	.466	0.870	0.599 1.264	.182	1.076	0.966 1.198	.270	1.071	0.948 1.211	.489	1.056	0.904 1.234
Adjust. R ² ; AUC; H-L	.096	.780	.365	.035	.579	.516	.036	.608	.171	.030	.597	.996

Note. Results obtained in logistic Regression adjusted by child's sex and other comorbidity different to feeding disorder. FD: feeding disorder. In bold: significant association (.05 level). AUC: Area Under Roc. H-L: Hosmer-Lemeshow test.

Table 4 presents the logistic regressions, adjusted by child's sex and other comorbidities different to feeding disorder, measuring the association between parenting (measured at 3 years old) and feeding behaviors (measured at 4 and 5 years-old). Low scores in autonomy were statistically predictive of the presence of FD symptoms, impairment and consultation at age 4. Low scores in the

norms scale were statistically predictive of the presence of FD symptoms and impairment at age 5. Considering the incidence of feeding related behaviors during the complete follow-up (age 3-4-5 years-old), high scores in APQ-poor monitoring, high scores in APQ-inconsistency, and low scores in norms scale were statistically predictive of the presence of FD symptoms. Additionally, high

Table 4
Longitudinal association between parenting practice scores (APQ-Pr at age 3) and FD variables (at ages 3-4-5)

Parenting style score	DSM diagnosis of FD			Presence of DSM FD symptoms			Impairment due to FD			Professional Help for FD		
	p	OR	95% CI	p	OR	95% CI	p	OR	95% CI	p	OR	95% CI
FD at age 4 (N=604)												
Positive	.793	1.068	0.651 1.753	.140	1.088	0.973 1.217	.125	1.105	0.973 1.256	.071	1.201	0.985 1.464
Involvement	.319	0.858	0.635 1.160	.783	1.008	0.952 1.067	.989	1.000	0.938 1.067	.320	0.953	0.866 1.048
Poor monitoring	.882	0.966	0.612 1.525	.124	1.095	0.975 1.230	.491	1.047	0.919 1.192	.201	0.882	0.728 1.069
Corporal punishment	.269	0.474	0.126 1.780	.146	1.155	0.951 1.403	.078	1.207	0.979 1.488	.169	1.225	0.918 1.635
Inconsistent discipline	.493	1.159	0.760 1.769	.192	1.072	0.966 1.189	.327	1.059	0.944 1.188	.511	1.056	0.898 1.242
Norms	.202	0.851	0.664 1.090	.449	0.965	0.879 1.059	.879	1.009	0.904 1.126	.837	0.984	0.848 1.143
Autonomy	.576	0.868	0.528 1.425	.004	0.850	0.762 0.949	.004	0.836	0.742 0.943	.011	0.800	0.675 0.949
Adjust. R ² ; AUC; H-L (p)	.137	.819	.998	.061	.641	.294	.056	.626	.224	.068	.646	.553
FD at age 5 (N=574)												
Positive	.922	0.980	0.646 1.484	.096	1.108	0.982 1.250	.904	0.992	0.865 1.137	.453	0.919	0.738 1.145
Involvement	.345	0.887	0.691 1.138	.210	0.961	0.903 1.023	.710	1.014	0.943 1.090	.492	0.957	0.844 1.085
Poor monitoring	.721	0.929	0.619 1.394	.166	1.092	0.964 1.236	.984	1.002	0.865 1.160	.612	1.061	0.844 1.333
Corporal punishment	.776	1.097	0.580 2.075	.830	1.024	0.828 1.265	.749	1.042	0.810 1.341	.795	1.053	0.713 1.555
Inconsistent discipline	.442	0.849	0.559 1.289	.804	1.015	0.905 1.137	.408	1.057	0.927 1.206	.557	0.935	0.746 1.171
Norms	.238	0.846	0.642 1.117	.012	0.887	0.808 0.974	.010	0.872	0.786 0.968	.240	0.902	0.759 1.071
Autonomy	.617	0.890	0.563 1.406	.835	1.014	0.893 1.151	.826	1.017	0.874 1.184	.972	0.995	0.766 1.293
Adjust. R ² ; AUC; H-L	.100	.784	.944	.034	.607	.292	.031	.593	.674	.043	.655	.385
FD at age 3-4-5 (N=574)												
Positive	.687	1.065	0.783 1.449	.108	1.074	0.985 1.171	.235	1.058	0.964 1.161	.736	1.021	0.904 1.153
Involvement	.150	0.877	0.734 1.049	.521	1.014	0.971 1.060	.509	1.016	0.969 1.065	.748	0.990	0.929 1.054
Poor monitoring	.868	0.975	0.720 1.319	.034	1.103	1.007 1.209	.380	1.044	0.949 1.149	.297	1.069	0.943 1.212
Corporal punishment	.808	1.064	0.645 1.755	.105	1.137	0.973 1.328	.038	1.187	1.010 1.396	.059	1.214	0.993 1.484
Inconsistent discipline	.545	0.917	0.691 1.215	.027	1.099	1.011 1.195	.032	1.102	1.008 1.204	.807	1.014	0.904 1.138
Norms	.107	0.849	0.695 1.036	.030	0.920	0.853 0.992	.223	0.952	0.879 1.031	.401	0.957	0.865 1.060
Autonomy	.383	0.868	0.632 1.192	.694	0.982	0.899 1.074	.563	0.972	0.885 1.069	.186	0.920	0.814 1.041
Adjust. R ² ; AUC; H-L	.087	.715	.752	.055	.600	.127	.039	.599	.498	.031	.611	.076

Note. Results obtained in logistic Regression adjusted by child's sex and other comorbidity different to feeding disorder. FD: feeding disorder. In bold: significant association (.05 level). AUC: Area Under Roc. H-L: Hosmer-Lemeshow test.

scores in APQ-corporal punishment and APQ-inconsistency were statistically predictive of impairment due to FD. No statistical longitudinal associations were found neither for parenting practices scores and the presence of DSM-IV FD nor for consultation.

Discussion

The aims of this study were firstly to examine the prevalence of FD diagnosis, symptoms, impairment, and seek of professional help in Spanish preschoolers at ages 3 to 5 and, secondly, to explore the relationship between parenting practices and feeding problems and its clinical related behavior. Data showed that the prevalence of FD diagnosis during the preschool period was 1.56%. This is aligned to findings from Al-Jawadi and Abdul-Rhman (2007) who found the prevalence of FD to be 2% in a sample of 3,079 Irakian children using the DSM-IV criteria. In this study, the prevalence of FD diagnosis remained constant throughout the preschool period demonstrating the stability of the diagnosis over time. The presence of FD symptoms during the preschool period was 33.30%, which is consistent with findings from Linscheid, Budd, and Rasnake (2003) and Ramsey, Gisel, McCusker, Bellavance, and Platt (2002) whom found presence of feeding problems among 25-45% of children. The percentage of preschoolers presenting FD symptoms in our study decreased from 20.3% at age 3 to 12.9% at age 5, showing a gradual decreased, may be due to the fact that in this developmental period children learn a lot of social rules and decrease their easy distractibility during mealtimes. The percentage of impairment and seek of professional help also decreased over time. The most prevalent FD symptoms presented in this study were problematic behavior during mealtimes (26.83%) and limited food repertoire (14.34%). Overall, the prevalence of FD symptoms, impairment and seek of professional help during the preschool period are strikingly high and demonstrate that these problematic behaviors are very common among young children. Data also suggests that specific parenting practices predict children's feeding behavior, while other parenting prac-

tices do not. A consistent discipline and giving children norms and autonomy at meals time in early stages of development are beneficial and a good predictor of less feeding-related problems. This finding supports Rhee, Lumeng, Appugliese, Kaciroti, and Bradley (2006) who demonstrated that children of strict authoritarian parents had almost a fivefold increase in odds of having overweight children in first grade than authoritative parents. Also, Taylor, Wilson, Slater, and Mohr (2011) found that style dimensions of demandingness and responsiveness were associated with healthy weight-related attitudes in children. High levels of positive parenting were associated with better child functioning as also found (Healey, Flory, Miller, & Halperin, 2011), while the use of corporal punishment as a disciplinary mean increases the impairment caused by feeding problems. Research has also suggested that parental practices such as warmth/connection in combination with parental structure/rules are associated with fewer disordered eating behaviors in adolescents (Enten & Golan, 2009).

Some aspects of this study could be improved: parenting practices were self-reported which is subject to potential biases of wanting to appear as "good parents". Second, families from high SES were overrepresented in the sample. Nevertheless, the study had many strengths. The longitudinal design enabled the study of developmental feeding trends of preschoolers over time in a large community sample of preschoolers, which allowed for an accurate representation of the general population and gave the study more validity. Overall, this study provided a great insight to the prevalence of feeding problems in the general population as well as the importance of parenting practices and their effects on children's feeding behaviors. Based on the findings from this study, the dietary and eating behaviors of young children should be a primary concern to all parents and healthcare professionals since almost half of the children population experiences a feeding problem during childhood and FD appear to be a quite stable diagnosis. Acknowledging the impacts of different parenting practices allows parents to be aware of their behavior and make any necessary modifications in order to benefit the development of their child; also general practitioners should notice this and implement the assessment of these parental practices in their routines.

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