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PREDICTORS OF MATERNAL MENTAL WELL-BEING AND FEEDING ATTITUDES IN THE COMPLEMENTARY FEEDING PRACTICES: A CROSS-SECTIONAL STUDY IN KARABÜK PROVINCE

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Abstract

Objectives: This study aimed to investigate the relationship between mothers' complementary feeding practices, mental well-being, and attitudes toward the feeding process during the complementary feeding period.

Materials and Methods: In this cross-sectional, descriptive study, data were collected from 369 mothers and their infants aged 12–24 months. The "Mother's Attitudes Towards the Feeding Process Scale (MATFPS)" and the "Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)" were utilized for data collection. Demographic characteristics of the mothers and infants, breastfeeding behaviors, and complementary feeding practices were assessed.

Results: The mean exclusive breastfeeding duration was 17.99 ± 7.07 weeks, and complementary feeding began at 5.52 ± 0.79 months. Overall, 56.4% of infants were exclusively breastfed for six months. Weak negative correlations were found between MATFPS and WEMWBS scores ($p < 0.001$) and between maternal age and WEMWBS scores ($p = 0.01$). WEMWBS score, feeding activities, complementary feeding method, and timing predicted MATFPS scores ($R^2 = 0.21$), while maternal age, number of children, and feeding activities predicted WEMWBS scores ($R^2 = 0.13$) ($p < 0.001$).

Conclusion: The study showed that better maternal mental well-being positively influenced attitudes toward complementary feeding. Midwives, nurses, and nutritionists in primary health care can play an important role in improving complementary feeding practices. Increased health literacy among people with chronic diseases positively affects rational medicine use. Expanding education and counselling services in primary care is recommended to promote rational medicine use, support treatment adherence, and reduce preventable medication-related problems.

Keywords: Chronic disease, health literacy, primary healthcare.

Introduction

According to the "Convention on the Rights of the Child," every infant and child has the right to proper nutrition. The World Health Organization (WHO) and the United Nations International Children's Emergency Fund (UNICEF) recommend exclusive breastfeeding for infants up to six months of age and the continuation of breastfeeding with complementary foods for at least two years.[1] Feeding during infancy is a process in which both the parent and the child actively participate and interact reciprocally.[2] This period is crucial for establishing eating behaviors that form the foundation of good nutrition and healthy growth.[3]

Numerous studies have reported that breastfeeding characteristics influence eating habits in later life. One study observed that children who were breastfed consumed more vegetables and enjoyed eating vegetables at 15 months compared to those fed with formula.[4] Breastfeeding characteristics are closely linked to maternal mental well-being. Oxytocin release during breastfeeding is known to reduce anxiety and promote physiological changes and psychological adaptations.[5] The relationship between maternal mental well-being and breastfeeding is bidirectional; mental health disorders can impair breastfeeding success, while challenges or the absence of breastfeeding have been associated with postpartum depression and anxiety.[6] Significantly, the literature reports that mothers' anxiety levels, personality traits, and mental well-being influence the feeding practices of infants aged 6–12 months[7] and that maternal depressive symptoms are correlated with the eating behaviors of school-aged children.[8]

From six months onward, breast milk alone cannot meet an infant's nutritional needs, making complementary feeding essential. Delayed or inappropriate introduction may negatively impact growth and development.[3] The complementary feeding period is critical for both physical and cognitive development. During this time, the brain grows at a rapid rate. Therefore, the timing, amount, and duration of certain nutrients can have positive and negative effects. Complementary feeding entails more than ensuring adequate nutrient

intake; it is also significant to consider how a child is fed, not just what they are fed.[9] The family system in which a child is raised plays an active role in forming behavior patterns that persist throughout life. Parents' eating habits and feeding strategies are dominant determinants of a child's eating behavior.[10] A study conducted with school-aged children reported that feeding and parenting styles influenced their consumption of unhealthy snacks.[11]

Considering the impact of feeding habits and parental attitudes acquired during infancy on adulthood, this study aimed to examine the relationship between mothers' complementary feeding practices, mental well-being, and attitudes toward the feeding process during the complementary feeding period.

Materials and Methods

Study Design and Population

This study was designed as a cross-sectional descriptive correlational study. It was conducted between April 15 and September 15, 2023, with mothers of infants aged 12–24 months who visited family health centers and community health centers in the central district of Karabük for well-child follow-up.

Population and Sample Size

The study population comprised mothers residing in Karabük who had infants aged 12–24 months and whose infants had transitioned to complementary feeding. The primary reason for selecting this age group is related to the developmental characteristics of the complementary feeding period. The 6–12-month stage is often considered a transitional period in which infants are introduced to complementary foods and primarily engage in tasting, exploring textures, and gradually adapting to non-milk foods.[12] In contrast, by 12 months of age, most infants have been exposed to a wide variety of foods, have developed

more stable eating patterns, and complementary feeding practices become more established and measurable.

According to the 2023 address-based population registration statistics of the Turkish Statistical Institute, there were a total of 2,137 infants aged 12–24 months in Karabük province.[13] The minimum required sample size was calculated as 329 using the sample formula with a 95% confidence interval and a 5% margin of error. Anticipating potential data losses, the researchers planned to include at least 10% more mothers in the study.

The study included literate mothers who lived in Karabük province, had infants aged between 12 and 24 months, and gave informed consent to participate. Mothers of infants with chronic diseases or food allergies were not included. Using a simple random sampling technique, 11 family and community health centers were selected. Mothers who visited these centers during the study period and met the inclusion criteria were recruited. A total of 369 mothers who completed the questionnaire in full were included in the final analysis. A post-hoc power analysis based on the final sample (n=369) and the correlation coefficient (r = -0.255) yielded a power of 0.99, confirming the high statistical sensitivity of the study. The feeding-related characteristics of the infants were detailed in Table 1.

Table 1. Feeding patterns of infants

	0-6 months (n=369)	**6-12 months (n=369)**	**12-18 months (n=286)**	**18-24 months (n=182)**
	n (%)	**n (%)**	**n (%)**	**n (%)**
Exclusive human milk	208 (56.37)	-	-	-
Exclusive formula	4 (1.08)	-	-	-
Human milk + water	12 (3.25)	-	-	-
Human milk + formula	87 (23.58)	12 (3.25)	-	-
Human milk + complementary food	33 (8.94)	241 (65.31)	196 (68.53)	112 (61.54)
Formula + complementary food	1 (0.27)	56 (15.18)	49 (17.13)	19 (10.44)
Human milk + formula + complementary food	24 (6.50)	59 (15.99)	24 (8.39)	13 (7.14)
Only complementary food	-	1 (0.27)	17 (5.94)	38 (20.88)

Data Collection

Data were collected using the "Participant Information Form," the "Mother's Attitudes Towards the Feeding Process Scale," and the "Warwick-Edinburgh Mental Wellbeing Scale." Mothers who visited the selected family and community health centers were provided verbal and written information about the research in line with the "Informed Consent Form (ICF)." Mothers who agreed to participate and signed the ICF were asked to complete the forms without disrupting healthcare services. Completing the forms took approximately 20 minutes.

Mothers' Body Mass Index (BMI) values (kg/m^2) were calculated using standards from the Centers for Disease Control and Prevention.[17] For infants' height and weight percentile values, reference values provided by Neyzi et al. (2008) 14 were used.

The Participant Information form contained a total of 27 questions that inquired about the sociodemographic characteristics of mothers and their infants, as well as complementary feeding behaviors. The form was prepared by the researchers following the literature.[6,15]

The Mother's Attitudes Towards the Feeding Process Scale (MATFPS), originally developed in Turkish by Dilsiz et al. (2018), includes 27 items and is designed for use with mothers of children aged 9 to 72 months.[17] Items are rated on a five-point Likert scale, from 1 (Never) to 5 (Always), yielding a total score between 27 and 135. Higher scores reflect more problematic attitudes related to the feeding process. The original scale demonstrated high internal consistency, with a Cronbach's alpha of 0.91. It encompasses five subdimensions: emotional negativity during meals, concerns about inadequate or unbalanced nutrition, maladaptive feeding behaviors, pressure-based feeding, and sensitivity to external opinions.[17] In the present study, the Cronbach's alpha was calculated as 0.90.

The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS), originally developed by Tennant et al. (2007) and adapted to Turkish by Keldal (2015), is a unidimensional instrument comprising 14 positively worded items.[18,19] It is intended for use with individuals aged 16 to 70 years. Each item is rated on a five-point Likert scale from 1

(Strongly disagree) to 5 (Strongly agree), resulting in total scores ranging between 14 and 70. Higher total scores reflect better mental well-being. The original version of the scale demonstrated strong internal consistency with a Cronbach's alpha of 0.89.[19] In the current study, the scale's Cronbach's alpha was calculated as 0.93.

Ethical Considerations

This study was carried out in accordance with the ethical principles of the Declaration of Helsinki. Before data collection, approval was obtained from the Non-Interventional Clinical Research Ethics Committee of Karabük University (Protocol No/Date: E-77192459-050.99-232724/2023), followed by institutional permission from the Karabük Provincial Health Directorate (Protocol No/Date: E-86662556-604.01.02-213012244/2023). In addition, authorization to use the relevant measurement tools was secured via email from the original authors. Written informed consent was included on the first page of the questionnaire, clearly outlining the study's purpose, assurance of confidentiality, voluntary nature of participation, and the participants' right to withdraw at any stage.

Statistical Analysis

Data analysis was performed using the Statistical Package for Social Sciences (SPSS) software, version 24. Descriptive statistical methods (number, percentage, mean, standard deviation, median, minimum, maximum) were utilized for data evaluation. The normality of data distribution was assessed using the Kolmogorov-Smirnov test, supplemented by an evaluation of Skewness and Kurtosis coefficients.[19] Variables with Skewness and Kurtosis values within the ±1.5 range were considered to satisfy the normality assumption for parametric procedures. Parametric tests were used for variables with normal distribution, while non-parametric tests were applied to those without normal distribution. All comparative findings were presented with their respective test statistics alongside p-values to provide a comprehensive overview of the analysis. For variables where the ANOVA test showed significance, Bonferroni or Tamhane post-hoc tests were conducted. Linear regression analysis was used to determine the predictors of MATFPS and WEMWBS

scores. Additionally, a post-hoc power analysis was performed using the deductive method based on the final sample (n=369) and observed effect sizes to verify the statistical sensitivity of the study. Results were evaluated within a 95% confidence interval, and $p<0.05$ was considered statistically significant. The study adhered to the STROBE guideline for cross-sectional studies.[20]

Results

Data were obtained from 369 mothers and their infants. Descriptive characteristics of mothers and infants are given in Table 2.

It was determined that mothers with university-level education or higher had significantly lower WEMWBS scores than mothers with high school education or less (U=-2.99/p = 0.003/r=0.02). Among mothers, 69.92% were housewives or on maternity leave, and they had significantly higher WEMWBS scores than working mothers (U=-2.14/p = 0.03/r=0.012). Among the participants, 62.87% (n = 232) had income equal to their expenses, and these individuals had significantly higher MATFPS scores compared to those whose income exceeded their expenses (W=4.33/p = 0.01,/η2=0.02). It was found that 77.24% (n=285) of the mothers assessed their infants' development as normal, and mothers who believed their infants' development was behind that of their peers had significantly higher MATFPS scores compared to others (F=7.79/p < 0.001,/η2=0.04). It was determined that 49.32% (n=182) of the participants started complementary feeding upon the recommendation of a doctor, and these individuals had significantly lower MATFPS scores compared to those who started upon the recommendation of elder family members (F=3.07/p=0.04/η2=0.01). It was found that in 87.53% (n=323) of cases, the person feeding the infant with complementary foods was the mother or father. It was found that 68.56% of infants ate complementary meals with family members. Mothers of infants who ate during family mealtimes had significantly lower MATFPS scores than those whose infants ate separately (t=-5.64/p<0.001/d=0.63). In addition to this, 59.35% (n=219) of the infants consumed their complementary meals independently. Mothers of infants whose

complementary meals were fed by someone else had significantly higher MATFPS scores compared to those whose infants ate independently (W=15.39/p<0.001/η2=0.08). It was determined that 52.58% (n=194) of the infants did not engage in any other activity while eating and only ate; these infants' mothers had lower MATFPS scores (F=26.16/p<0.001/η2=0.12) and higher WEMWBS scores (X=12.31/p = 0.002/) (Table 3).

Table 2. Descriptive characteristics of mothers and infants (n=369)

Variables		**Mean±SD**
Mothers'	Age (years)	30.55±4.61
	Body weight (kg)	66.66±12.63
	Body height (cm)	162.86±13.52
	BMI (kg/m^2)	24.94±4.25
	The number of living children	1.55±0.82
Infants'	Birth gestation (weeks)	38.12±1.83
	Age (month)	17.02±4.31
	Birth weight (gr)	3229.20±496.74
	Current weight (gr)	10.86±2.00
	Current weight percentile	47.26±30.45
	Current height (cm)	79.18±9.21
	Current height percentile	42.47±35.25
Infants' feeding features	Duration of full breastfeeding	17.99±7.07
	Time to start complementary food	5.52±0.79
	Duration to finish a single main	19.46±9.71
		n (%)
Mothers' information about breastfeeding	No, she didn't get any information.	60 (16.26)
	Yes, she's got information.	309 (83.74)
Source of information about transition to complementary food*	Healthcare professionals	240 (65.04)
	Books	144 (39.02)
	Internet	226 (61.25)
	Written/visual media	118 (31.98)
	Family elders	129 (34.96)
	Past experiences	76 (20.60)
	Other	1 (0.27)

BMI: Body Mass Index

* More than one option is selected.

Table 3. Comparison of sociodemographic and nutritional characteristics with MATFPS and WEMEBS

Variables		n (%)	MATFPS Mean±SD Median (Min-Max)	p	WEMEBS Mean±SD Median (Min-Max)	p
Mothers' Educational Status	High school and lower	119 (32.25)	59.84±16.53	t=-1.30 0.19	56.00 (27.00-70.00)	**U=-2.99 0.003 r=0.02**
	University or higher	250 (67.75)	62.32±17.28		54.00 (15.00-70.00)	
Mothers' Occupational Status	Housewife and maternity leave	258 (69.92)	61.16±17.26	t=-0.61 0.54	55.00 (15.00-70.00)	**U=-2.14 0.03 r=0.012**
	Full-time, part-time, and work from home	111 (30.08)	62.35±16.63		53.00 (18.00-70.00)	
Socioeconomic Status	Income less than expense (a)	57 (15.45)	61.29±16.90	**W=4.33 0.01 b>c η2=0.02**	51.54±9.66	F=2.03 0.13
	Income equals expense (b)	232 (62.87)	63.04±17.84		53.32±9.94	
	Income more than expenses (c)	80 (21.68)	57.27±14.02		55.03±10.71	
Infant development according to the mother	Behind compared to peers (a)	15 (4.06)	68.53±16.35	**F=7.79 <0.001 a>c; b>c η2=0.04**	53.00 (28.00-70.00)	X=0.16 0.92
	Normal (b)	285 (77.24)	62.79±17.28		55.00 (18.00-70.00)	
	Ahead compared to peers (c)	69 (18.70)	54.73±14.42		55.00 (15.00-70.00)	
Who advised you to start complementary food?	Of my own volition (a)	165 (44.72)	62.46±16.37	**F=3.07 0.04 b>c η2=0.01**	56.00 (15.00-70.00)	X=0.90 0.63
	Family elders' suggestion (b)	22 (5.96)	68.59±20.86		55.00 (38.00-70.00)	
	Doctor's suggestion (c)	182 (49.32)	59.81±16.98		54.00 (18.00-70.00)	
The person feeding the complementary food	Mother or father	323 (87.53)	61.12±17.30	t=-1.19 0.23	53.76±10.16	t=1.75 0.08
	Babysitter or grandmother	46 (12.47)	64.32±15.09		50.97±9.35	
Infant's mealtime	With other family members, at mealtime	253 (68.56)	58.26±16.18	**t=-5.64 <0.001 d=-0.63**	55.00 (15.00-70.00)	U=-0.62 0.53
	At a separate time, other than family members	116 (31.44)	68.63±16.82		55.00 (21.00-70.00)	
Infant's eating pattern	Eat independently (a)	219 (59.35)	57.96±15.46	**W=15.39 <0.001 b>a; b>c η2=0.08**	55.00 (15.00-70.00)	X=4.31 0.11
	Is fed by someone else (b)	126 (34.15)	68.48±18.46		54.00 (21.00-70.00)	
	Both (c)	24 (6.50)	57.45±11.64		50.50 (18.00-70.00)	

Activities during complementary feeding	Only eats, does not engage in other activities (a)	194 (52.58)	55.85±15.51	**F=26.16 <0.001 b>a; c>a η2=0.12**	56.00 (15.00-70.00)	**X=12.310 0.002 a>c r=0.03**
	Watches cartoons on a phone, tablet, or television (b)	71 (19.24)	69.28±17.76		55.00 (28.00-69.00)	
	Plays with toys or flashcards (c)	104 (28.18)	66.79±15.62		52.00 (27.00-70.00)	

U: Mann-Whitney U test; W: Welch test; t: Independent Samples T Test; F: One-way ANOVA; X: Kruskal-Wallis test; d: Cohen's d; η^2: Eta-squared; r: nonparametric effect size; p<0.05 indicates a significant difference.

In the study, there was a weak positive correlation between the infant's birth weight and the duration of exclusive breastfeeding (r=0.124/p=0.01). A weak positive correlation was identified between the timing of complementary feeding initiation and both the infant's birth weight (r=0.105/p = 0.04) and the duration of exclusive breastfeeding (r=0.269/p < 0.001). Notably, a weak negative correlation was observed between the WEMWBS score and maternal age (r=-0.133/p = 0.01) as well as between WEMWBS and MATFPS scores (r=-0.255/p < 0.001) (Table 4).

Table 4. Correlation of MATFPS and WEMEBS with some variables

		Mothers' age	**Infants' birth weight (g)**	**Duration of full breastfeeding (weeks)**	**Time to start complementary food (month)**	**MATFPS**
Infants' birth weight (g)	r	-0.080	1			
	p	0.123				
Duration of full breastfeeding (weeks)	r	-0.047	0.124	1		
	p	0.37	**0.01**			
Time to start complementary food (month)	r	0.011	0.105	0.269	1	
	p	0.83	**0.04**	**<0.001**		
MATFPS	r	-0.049	-0.019	0.011	0.027	1
	p	0.346	0.71	0.82	0.59	
WEMEBS	r	-0.133	0.014	-0.014	-0.025	-0.255
	p	**0.01**	0.79	0.78	0.62	**<0.001**

r=Pearson's correlation coefficient; The bold values are significant at the 0.05 level (2-tailed); p<0.05 indicates a significant difference.

It was found that activities during complementary feeding (p<0.001), WEMWBS score (p<0.001), the infant's method of consuming complementary feeding (p<0.001), and meal timing (p=0.008) significantly predicted the total MATFPS score ($R^2 = 0.21$; $p < 0.001$). Additionally, maternal age (p<0.001), total number of children (p=0.02), and activities during complementary feeding (p=0.03) were significant predictors of the total WEMWBS score ($R^2 = 0.13$; p<0.001) (Table 5).

Table 5. Multivariable linear regression of factors related to the MATFPS and WEMEBS

Method	Variables	B	Beta	t	p	VIF
Dependent variable: MATFPS						
Stepwise	Constant	85.779		18.159	**<0.001**	
	Activities during complementary feeding[a]	-7.880	-0.229	-4.441	**<0.001**	1.207
	Infant's eating pattern[b]	6.172	0.172	3.363	**<0.001**	1.179
	Infant's meal time[c]	-5.083	-0.138	-2.656	**0.008**	1.230
	WEMEBS	-0.351	-0.207	-4.366	**<0.001**	1.013
F=25.166; Model p<0.001; R^2=0.21; Durbin-Watson=2.068						
Dependent variable: WEMEBS						
Stepwise	Constant	62.215		17.831	**<0.001**	
	Mothers' age	-0.394	-0.182	-3.389	**<0.001**	1.070
	The number of living children	1.443	0.119	2.233	**0.02**	1.056
	Activities during complementary feeding[a]	2.260	0.112	2.135	**0.03**	1.013
F=5.615; Model p<0.001; R^2=0.13; Durbin-Watson=1.987						

VIF: Variance inflation factor; R^2: Explanatory power of the variable; B: Estimated coefficient of the independent variable in the linear predictor; p<0.05 indicates a significant difference; [a]Reference category: Only eats, does not engage in other activities; [b]Reference category: Is fed by someone else; [c]Reference category: With other family members, at mealtime.

Discussion

Our study found that improved mental well-being among mothers with infants aged 12–24 months is linked to more positive attitudes toward complementary feeding, aligning with previous research on maternal mental health and feeding behaviors.[6,21] While extensive studies focus on breastfeeding, research on maternal well-being during complementary

feeding remains limited. For example, Jiang et al. (2022) reported that depression, anxiety, and stress symptoms in mothers with infants under six months negatively affect breastfeeding attitudes and self-efficacy.[6] According to the 2022 Türkiye Health Survey, 26.7% of infants were exclusively breastfed in the first six months[22], while the WHO reports a global rate of 44%.[1] Our study found a higher rate of 56.37%, though still below the desired levels. Studies show that feeding attitudes are crucial for child development.[24] In Türkiye, Küçük et al. (2023) found that mothers perceiving insufficient milk were 6.5 times more likely to start complementary feeding early.[24] In our study, the mean initiation age was 5.52 ± 0.79 months, consistent with the literature. Maternal beliefs and attitudes during this period shape children's long-term eating habits.[23] Additionally, Wolstenholme et al. (2020) reported that parents' negative emotions can lead to fussy eating behaviors in children over one year, affecting mealtime dynamics.[21] These findings emphasize the critical role of maternal psychological well-being not only in breastfeeding but also in complementary feeding, underscoring the need for support during this phase.

A mother's knowledge is vital for ensuring proper breastfeeding duration and a healthy transition to complementary feeding in line with international guidelines.[26] This study showed that many mothers knew about breastfeeding, with healthcare professionals and the Internet being key information sources. Mothers who followed medical advice showed more positive attitudes. In Türkiye, Karataş et al. (2022) found that nearly half of the mothers received breastfeeding information from midwives or nurses before birth, and 48.5% were influenced by healthcare professionals during complementary feeding.[26] While midwives and nurses in primary care are key sources, the Internet's widespread use must also be acknowledged. Strengthening primary care and ensuring mothers' access to reliable information is crucial, as increased maternal knowledge positively affects children's eating habits.[23] A study where nurses guided primiparous mothers found improved feeding routines and reduced use of non-responsive practices like pressuring or soothing with food.[28] Additionally, Matvienko-Sikar (2018) highlighted that parental information needs vary across the stages of complementary feeding.[25] Thus, maternal nutrition education

should begin before pregnancy and continue through postpartum, with content tailored to the child's developmental stage and supported by midwives, nurses, and dietitians.

In the literature, the relationships between the frequency of family meals and eating patterns, obesity, irregular eating habits, and psychosocial effects have been emphasized.[10] This study found that infants who ate without distractions and dined with family had a positive effect on maternal feeding attitudes, whereas being fed by others had a negative effect. These findings support research highlighting the benefits of self-feeding in fostering positive feeding practices. For instance, Bialek-Dratwa et al. (2022) observed that infants following the Baby-Led Weaning (BLW) approach were more likely to partake in family meals by taking food from the family table compared to those fed using the traditional spoon-feeding method.[28] These findings underscore the significance of family meals not only for nutritional intake but also for promoting social interaction. Similarly, in a qualitative study by Spence et al. (2016), the social role of the family environment was emphasized, and it was reported that, in most cases, eating together and staying away from television were stated as the primary reasons for family meals.[29] These findings support the results obtained in our study, indicating that family meals positively influence both the feeding process and mothers' attitudes toward it.

In our study, increasing maternal age was associated with a negative impact on maternal mental well-being, whereas having a greater number of living children and infants eating without engaging in other activities positively predicted maternal mental well-being. This finding is consistent with the literature. For instance, a qualitative study reported that parents' experiences with previous children influenced their feeding practices, enabling them to develop improved strategies through learned experience.[29] Consequently, mothers raising their second or subsequent children may feel more confident and experienced in complementary feeding processes, which, in turn, can positively affect their mental well-being. Mothers with multiple children may feel more confident in complementary feeding, positively impacting their mental well-being by reducing stress and enhancing interaction.

However, increasing maternal age may negatively affect well-being due to physical fatigue, health issues, and reduced social support, complicating childcare and feeding processes.

Our study indicated that lower maternal education levels and being a homemaker or on maternity leave positively influenced maternal mental well-being.[30] Found that among women taking 12 weeks or less of maternity leave, each additional week reduced the likelihood of experiencing postpartum depressive symptoms.[31] A lower level of maternal education is thought to increase the likelihood of being a homemaker. Consequently, it can be inferred that mothers with lower education levels may experience better mental well-being compared to working mothers, as they have the opportunity to dedicate their entire day to caring for their infants. Additionally, our study revealed that higher socioeconomic status was associated with more positive maternal attitudes toward the feeding process. This improvement may be attributed to the fact that families with higher socioeconomic status can more easily access healthy food choices and professional support, such as nutritional counseling. In addition, higher socioeconomic status may allow parents to have more control over their working conditions and to allocate more time to their children's feeding processes. These factors can lead to an improvement in mothers' attitudes related to the feeding process.

Limitations and Strengths

The primary limitation of our study is the inclusion of only mothers with infants aged 12–24 months. This inclusion restricts the generalizability of the findings to infants aged 6–12 months, a period considered critical in the complementary feeding process. The secondary limitation of the study is the inability to account for other factors that may influence maternal mental well-being, given the study's design.

One of the strengths of this study is the inclusion of experts from different disciplines who could contribute to the subject matter within the research team. The participation of professionals such as pediatric nurses, midwives, and dietitians provided a

multidisciplinary perspective. This diversity allowed for more comprehensive results and recommendations by examining maternal and infant health from three viewpoints.

In conclusion, this study contributes to understanding the relationship between breastfeeding behaviors, maternal mental well-being, and attitudes during the complementary feeding period. Findings show that better maternal mental well-being positively influences feeding attitudes. The average exclusive breastfeeding duration was 17.99 ± 7.07 weeks, and the mean age for starting complementary feeding was 5.52 ± 0.79 months. Key predictors of maternal attitudes included the infant eating without distractions, being fed by others, attending family meals, and maternal mental health. In turn, maternal mental well-being was affected by maternal age, number of children, and the infant's mealtime behaviors.

The complementary feeding period is a critical transition that, if mismanaged, can lead to adverse health outcomes, making it important for both individual and public health. In this context, midwives and nurses—central figures in primary care—are well-positioned to provide education and support to improve maternal feeding practices. Furthermore, enhancing dietitian support for parents during the complementary feeding process within primary healthcare services is strongly recommended. Ultimately, collaboration among nurses, midwives, dietitians, and other healthcare professionals is essential for promoting healthy complementary feeding.

Ethical Considerations: This study adhered to the Declaration of Helsinki. Ethical approval was obtained from the Non-Interventional Clinical Research Ethics Committee of Karabük University (Protocol No/Date: E-77192459-050.99-232724/2023), followed by institutional permission from the Karabük Provincial Health Directorate (Protocol No/Date: E-86662556-604.01.02-213012244/2023). Written informed consent was provided on the first page of the questionnaire, explaining the study's purpose, confidentiality, voluntary participation, and the right to withdraw at any time.

Conflict of Interest: The authors declare no conflict of interest.

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