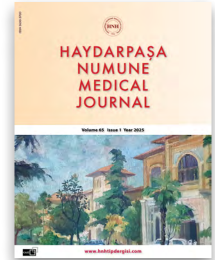
HAYDARPAŞA NUMUNE MEDICAL JOURNAL

DOI: 10.14744/hnhj.2025.67778
Haydarpasa Numune Med J 2025;65(4):313–319



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ORIGINAL ARTICLE

Evaluation of the Impact of Maternal Feeding Attitudes on Anthropometric Measurements in Aged 2–6 Years

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Abstract

Introduction: This study aimed to assess the influence of maternal feeding attitudes on the anthropometric measurements of children aged 2–6 years.

Methods: Mothers of children aged 2–6 years who applied to the outpatient clinics of the Family Medicine Clinic at Health Sciences University Şişli Hamidiye Etfal Training and Research Hospital were included in this study. The children's weight and height measurements were recorded, and the Sociodemographic Data Form was completed by the mothers. The Mother's Attitudes Towards the Feeding Process Scale (MATFPS) was used to evaluate maternal feeding attitudes. A p value of <0.05 was considered statistically significant.

Results: The study included 159 participants. The mean age of the children was 44.93 months. The mean weight was 16.67 kg, and the mean height was 102.06 cm. There were 29 children (18.2%) whose weight percentile and 44 children (27.7%) whose height percentile were outside the normal range (<25^{th} percentile or ≥97^{th} percentile). When the relationship between children's height and weight percentiles and the total MATFPS score was evaluated, a negative correlation was found between children's height and weight and the total MATFPS score (r=-0.236, p=0.003; r=-0.299, p<0.001, respectively). Children with height and weight percentiles <25p had the highest scores in the total and subscales of the MATFPS, whereas children with height and weight percentiles ≥97p had the lowest scores in the total and subscales.

Discussion and Conclusion: This study demonstrated that maternal feeding attitudes have an impact on children's weight percentiles. Specifically, as negative maternal feeding attitudes increased, a decrease in children's weight was observed. Therefore, maternal feeding practices should always be assessed during primary care follow-up visits.

Keywords: Child; feeding behavior; growth; maternal behavior.

Feeding practices are a critical concern for parents, particularly mothers, due to their significant influence on a child's early developmental trajectory. It is known that during the period from the cessation of breastfeeding at the age of 2 years until the age of 6 years, a child's nutrition is largely influenced by the attitudes and behaviors of the caregiver [1]. During early childhood, maternal feeding behaviors are essential for ensuring optimal growth and developmental outcomes. Moreover, this phase critically shapes the development of lifelong dietary patterns in children [2]. While the influence of the caregiver can direct the child toward healthy foods, coercive and inappropriate attitudes may lead to nutritional problems in the child [1–3]. Authoritarian and coercive feeding practices, such as forcing children to eat, are

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Submitted Date: 28.02.2025 **Revised Date:** 03.07.2025 **Accepted Date:** 22.07.2025
Haydarpaşa Numune Medical Journal

associated with increased eating difficulties, including food neophobia and pickiness [4]. Conversely, positive feeding strategies, such as modeling and repeated taste exposure, are associated with healthier eating habits [5].

For some parents, having an overweight child reinforces the belief that their child is healthy and that their parenting is sufficient. However, this perception contributes to an increased prevalence of overweight and obesity in children [6]. In contrast, the negative impact of maternal restrictive and coercive attitudes on children's weight has been demonstrated [7,8].

In the evaluation of nutritional status, monitoring children's growth is essential [9]. A key component of routine child health follow-up in primary care is the performance of anthropometric measurements to monitor physical development and growth. Plotting these measurements on standardized growth charts allows the child's individual growth trajectory to be compared with peers of the same sex, thereby facilitating the identification of potential growth-related problems [10].

The objective of this study is to assess the influence of maternal feeding attitudes on anthropometric measurements of children aged 2–6 years, a period marked by post-breastfeeding transitions during which caregiver behavior has a critical impact on growth and development.

Materials and Methods

This was a single-center, descriptive study.

Population and Sample of the Study

Mothers of children aged 2–6 years who applied to the outpatient clinics of the Family Medicine Clinic at Health Sciences University Şişli Hamidiye Etfal Training and Research Hospital for any reason between 24.05.2022 and 24.07.2022 were included in the study. The study was conducted in accordance with the Declaration of Helsinki. The sample size was calculated using the Centers for Disease Control and Prevention (CDC) Epi Info software. The number of mothers with children in this age group who applied for any reason within a one-month period was 90, and over a three-month period, the sample size was calculated as 159 out of 270 with a 95% confidence interval. Parents of children with congenital or acquired diseases affecting growth and development, as well as those who declined to participate, were excluded.

Data Collection

After obtaining informed consent, a data collection form consisting of 17 questions was administered face-to-face by the researcher. In the first part of the form, questions addressed the mothers' age, education level, occupation, weight, height, and the fathers' height. In the second part, the Mother's Attitudes Towards the Feeding Process Scale (MATFPS) was used to assess maternal feeding attitudes. The scale was developed by Habibe Dilsiz and İhsan Dağ, and its validity and reliability analyses have been conducted. MATFPS consists of five subscales: Negative Affect During Meal (NADM), Attitudes towards Insufficient/Unbalanced Feeding (AIF), Negative Feeding Strategies (NFS), Forced Feeding (FF), and Reaction to the Viewpoints of Others (RVO). The scale includes a total of 27 items rated on a five-point Likert scale ranging from "Never" to "Always." The minimum possible score is 27, and the maximum possible score is 135. Higher scores on both the subscales and the total scale indicate an increase in problems related to maternal feeding attitudes [11].

Anthropometric measurements of the children at the time of application were obtained using an electronic scale with a sensitivity of 0.1 kg and a DESIS-ELW model stadiometer with a sensitivity of 0.1 cm. Percentile calculations were performed using reference values for body weight, height, head circumference, and body mass index (BMI) in Turkish children adapted by Neyzi et al. [12] BMI was calculated using the standard formula kg/m^2. The target height of the children was calculated using Tanner's formula based on midparental height, and the percentile value on the growth curve at age 18 years was used. For weight and height percentiles, values below the 25^{th} percentile were considered low, values between the 25^{th} and 97^{th} percentiles were considered normal, and values ≥97^{th} percentile were considered high. For BMI percentiles, values below the 25^{th} percentile were considered low, values between the 25^{th} and 95^{th} percentiles were considered normal, and values ≥95^{th} percentile were considered high.

Statistical Analysis

Descriptive statistics are presented as mean±standard deviation for normally distributed continuous variables and as median (interquartile range: Q1–Q3) for non-normally distributed variables, whereas categorical variables are presented as numbers and percentages. Categorical variables were examined using Pearson's chi-square test. The Kolmogorov–Smirnov test was employed to assess the normal distribution of continuous variables. For continuous variables that did not meet the assumption of normality, the Kruskal–Wallis H test was used to compare differences among the three groups. In cases where the Kruskal–Wallis test revealed a statistically significant difference, pairwise comparisons were conducted using the Mann–Whitney U test. To control for type I error due to multiple comparisons, the Bonferroni correction was applied, and the adjusted significance threshold was set at $p<0.0167$ for the three pairwise comparisons. The Spearman correlation test was used to examine relationships between continuous variables. The level of statistical significance was accepted as $p<0.05$. The SPSS 25.0 software package was used for data analysis.

Ethical Approval

Ethical approval was obtained from the Ethics Committee of Health Sciences University Şişli Hamidiye Etfal Training and Research Hospital on 24/05/2022 (Approval No: 3563).

Results

The study included 159 participants. The mean age of the participating mothers was 34.01±5.09 years (min=25, max=50). Of the mothers, 53.5% (n=85) were employed, and 84.9% (n=135) had a high school education or higher. The mean height of the mothers was 161.75±5.51 cm (min=147, max=178), and the mean height of the fathers was 176.06±6.72 cm (min=160, max=192). The mean BMI of the mothers was 25.45±4.98 kg/m^2 (min=17.30, max=42.68). Each participant had at least one and at most five children. Among the children, 54.1% (n=86) were girls. The mean age of the children was 44.93 months (min=24, max=72), with a mean weight of 16.67±3.73 kg (min=10.7, max=34) and a mean height of 102.06±10.31 cm (min=80, max=133). The mean BMI was 15.93±2.08 kg/m^2 (min=10.2, max=27.10).

The weight, height, and BMI percentile distributions of the children are shown in Table 1. A total of 29 children (18.2%) had a weight percentile outside the normal range (<25th or ≥97th percentile), 44 children (27.7%) had a height percentile outside the normal range, and 50 children (31.4%) had a BMI percentile outside the normal range (<25th or ≥95th percentile). The mean midparental height of the children was 168.37±7.94 cm (min=151, max=186). Thirteen children (8.2%) were below the target height percentile, whereas 146 children (91.8%) were at or above it.

The mean breastfeeding duration reported by mothers was 18.92±7.67 months (min=2, max=36). The responses of mothers to questions regarding the nutrition and follow-up process of their children are presented in Table 2.

As maternal age increased, there was a statistically significant increase in children's weight and BMI percentile values ($p=0.048$ and $p=0.047$, respectively). However, no statistically significant differences were found between mothers' education level or employment status and children's height, weight, or BMI percentiles ($p>0.05$).

A positive and statistically significant relationship was observed between mothers' weight and children's weight ($r=0.205$, $p=0.024$). Similarly, a positive and statistically significant relationship was found between mothers' BMI values and children's BMI values ($r=0.197$, $p=0.030$).

Table 1. The weight, height and BMI percentile distributions of the children

Anthropometric measure	<25p		25-97p (25-95p*)		≥97p (≥95p*)	
	n	%	n	%	n	%
Weight (<25p / ≥97p)	23	14.5	130	85.5	6	3.8
Height (<25p / ≥97p)	34	21.4	115	78.6	10	6.3
BMI (<25p / ≥95p)	38	23.9	109	68.6	12	7.5

*: For BMI, ≥95th percentile was used as the upper cutoff; for weight and height, ≥97th percentile was used. BMI: Body mass index.

Table 2. The responses of mothers to the questions about the nutrition and follow-up process of their children

	Response	n	%
Did you exclusively breastfeed your child for the first six months?	Yes	125	78.6
	No	34	21.4
Do you regularly take your child to infant-child follow-ups at the family health center?	Yes	153	96.2
	No	6	3.8
Did you use the vitamin D and iron supplements given during your child's follow-ups regularly and in the recommended amounts?	Yes	124	78.0
	No	35	22.0
Have you ever asked your doctor to prescribe food supplements - multivitamins - to increase your child's appetite or to support growth and development?	Yes	50	31.5
	No	109	68.5

The mean total MATFPS score was 65.82±17.19 (min=29, max=107). The mean subgroup scores were as follows: NADM, 14.94±5.8 (min=6, max=30); AIF, 24.74±7.12 (min=9, max=40); NFS, 10.24±3.95 (min=5, max=23); FF, 5.48±2.02 (min=4, max=12); and RVO, 10.42±3.7 (min=4, max=19).

When maternal age was compared with the total and subgroup MATFPS scores, a statistically significant negative correlation was observed only with the FF subgroup score (r=-0.194, p=0.014). No statistically significant differences were found between mothers' education level, employment status, or children's sex and the total MATFPS score (p>0.05). When MATFPS total and subgroup scores were compared according to whether mothers had one child or more, both the total MATFPS score and the FF subgroup score were significantly higher among mothers with one child (p=0.029 and p=0.007, respectively).

Analysis of the relationship between children's anthropometric percentiles and MATFPS scores revealed negative correlations between both children's height and weight and the total MATFPS score (r=-0.236, p=0.003 and r=-0.299, p<0.001, respectively). Children's weight was also negatively correlated with all MATFPS subgroups (r=-0.291, p<0.001 for NADM; r=-0.207, p=0.009 for AIF; r=-0.287, p=0.003 for NFS; r=-0.178, p=0.025 for FF; and r=-0.181, p=0.023 for RVO). Similarly, children's height was negatively correlated with all subgroups except AIF (r=-0.258, p=0.001 for NADM; r=-0.170, p=0.032 for NFS; r=-0.157, p=0.048 for FF; and r=-0.197, p=0.013 for RVO).

As shown in Table 3, children with height and weight percentiles <25p had the highest scores in the total and subgroup MATFPS scores, whereas children with height and weight percentiles ≥97p had the lowest scores in the total and subgroup scores. In addition, the NADM and NFS

Table 3. The distribution of participants' MATFPS subgroup scores according to their children's height, weight, and BMI percentiles

MATFPS subscale and total scores	Percentile	<25p[1] Median (Q1-Q3)	25-97p[2] Median (Q1-Q3)	≥97p[3] Median (Q1-Q3)	p*	Post-hoc comparisons**
Negative affect during meal	Weight	19 (13-24)	14 (10-18.25)	12.5 (10.25-14.25)	**0.041**	1-2: 0.021 1-3: 0.036 2-3: 0.477
	Height	16.5 (12.5-21)	14 (11-19)	10 (8-13.5)	**0.007**	1-2: 0.045 1-3: 0.004[a] 2-3: 0.026
	BMI	15.5 (11.75-19.75)	14 (10-18.5)	16.5 (13.75-19)	0.169	
Attitudes towards insufficient/unbalanced feeding	Weight	24 (31-31)	25 (19-29.25)	19.5 (15.25-25)	0.195	
	Height	24 (17.75-32.25)	25 (19-29)	26.5 (17.75-30.25)	0.979	
	BMI	27 (22-32)	22 (19-29)	24 (20.5-29)	0.134	
Negative feeding strategies	Weight	13 (9-15)	9 (7-12)	8 (6.75-10.25)	**0.027**	1-2: 0.015[b] 1-3: 0.031 2-3: 0.383
	Height	11 (7.75-15)	9 (7-12)	9 (7.25-11)	0.181	
	BMI	9.5 (7-15)	9 (7-12)	12 (8.5-14.75)	0.180	
Forced feeding	Weight	5 (4-8)	4 (4-7)	4 (4-4.75)	0.283	
	Height	4 (4-8.25)	5 (4-7)	4 (4-4)	0.068	
	BMI	5 (4-7)	4 (4-6)	6 (4-8.75)	0.095	
Reaction to the viewpoints of others	Weight	10 (8-14)	11 (8-13)	7 (6-9.75)	0.180	
	Height	11.25 (8-14.25)	10 (8-13)	10 (6-12.25)	0.361	
	BMI	10 (8-13.25)	11 (7.5-13)	12 (8.25-14)	0.676	
Total	Weight	70 (58-84)	62 (52-79)	48.5 (45.75-61.75)	**0.022**	1-2: 0.069 1-3: 0.016[c] 2-3: 0.044
	Height	69 (56-85.25)	62 (52-79)	59 (45.75-70.25)	0.179	
	BMI	70 (57.75-83)	61 (51.5-78)	73.5 (50-83.25)	0.135	

*: Kruskal–Wallis test was used. P<0.05 was considered statistically significant; **: Post-hoc analysis was performed using the Mann–Whitney U test with Bonferroni correction. For pairwise comparisons, p<0.0167 was considered statistically significant. [a,b,c]: Statistically significant after Bonferroni correction (p<0.0167). MATFPS: Mother's Attitudes Towards the Feeding Process Scale; BMI: Body mass index.

subgroups were associated with weight, whereas height was associated with NADM. BMI was not associated with any of the MATFPS subgroups.

Discussion

This study aimed to evaluate the effect of mothers' attitudes toward nutrition on their children's anthropometric measurements. Although most children had weight, height, and BMI values within the expected range for their age, a trend was observed in which children's height, weight, and BMI decreased as mothers' MATFPS scores increased. This finding suggests that as negative maternal feeding attitudes intensified, children's physical growth indicators declined.

Proper nutrition remains a central concern for parents in facilitating optimal child development. Parental approaches to early childhood nutrition have significant long-term implications for children's future eating habits, either fostering or hindering healthy dietary patterns [13]. At the same time, childhood nutrition also plays an important role in health outcomes during adulthood [14].

In the decision-making process regarding infant nutrition, many factors influence mothers, including infants' nutritional needs and perceived benefits, cultural factors, maternal health status, habits, level of knowledge, and the challenges and conveniences associated with breastfeeding [15].

In the literature, a study examining the relationship between maternal age and feeding practices reported that parents younger than 30 years tend to use more controlling feeding practices with their children [16]. As parental pressure-feeding practices increase, children are more likely to develop eating-related problems, such as picky eating, reduced enjoyment of food, and decreased food intake, leading to negative food-related outcomes and lower BMI values [17–19].

In our study, the finding that children's weight and height percentile values decreased as mothers' forced-feeding subscale scores increased is consistent with these reports. Similarly, the decrease in children's weight and BMI percentile values alongside increasing forced-feeding subscale scores as maternal age decreased further supports this association.

An important finding of our study was that as children's weight and height percentile values increased, decreases were observed in all maternal subscale scores and the total MATFPS score, except for the Attitudes towards Insufficient/Unbalanced Feeding subscale. However, the Attitudes towards Insufficient/Unbalanced Feeding subscale score was found to decrease with increasing BMI. In a similar study conducted in Türkiye using the MATFPS, a negative correlation was also observed between the total MATFPS score and BMI values [20].

This may be due to the fact that, during childhood, weight is perceived by mothers as an indicator of health [21]. In one study, nearly one-third of parents were unable to correctly assess their children's weight, while more than half of the parents of obese children made incorrect evaluations [21]. In another study examining how mothers perceive their children's appetite and appearance, it was reported that mothers' perceptions of their children's appearance often did not reflect the children's actual appearance, highlighting unrealistic maternal approaches [22]. It has been shown that mothers of underweight children tend to perceive their children as having higher weight, whereas mothers of overweight children tend to perceive their children as having lower weight [22].

In our study, a significant relationship was also identified between mothers' weight and BMI values and children's weight and BMI values [23]. In a study evaluating the impact of maternal feeding behaviors on early childhood obesity, mothers were followed during pregnancy and their children were monitored until the age of three, revealing a correlation between maternal overweight or obesity and the likelihood of children becoming overweight or obese [23]. In a review evaluating 11 studies from different countries, although childhood obesity was acknowledged as multifactorial, maternal overweight or obesity was found to have a significant impact on childhood obesity [24]. Similarly, in our study, supporting these findings, a correlation was identified between maternal weight and child weight [24].

When examining the relationship between the main focus of the study, MATFPS, and anthropometric measurements, it was observed that mothers of children with lower percentile values had higher mean MATFPS scores, whereas mean scores decreased as percentile values increased. This finding indicates that increasing problematic maternal feeding attitudes are likely to be associated with a decrease in children's anthropometric percentiles.

Numerous studies in the literature have demonstrated the impact of maternal feeding practices and eating habits on children's nutrition and development [25–27]. It is well known that one of the most common problems in early childhood that may lead to developmental issues is picky eating behavior, and that parent-related factors constitute the most significant cause of this behavior [28]. In a study evaluating the effects of maternal feeding practices at one year of age on children's nutrition at two years of age, the use of pressure to eat at one year was associated with lower fruit consumption at two years, whereas healthy eating modeling at one year was associated with higher vegetable consumption at two years [29].

The effect of differences in maternal feeding practices on children's weight was also demonstrated in a study evaluating Vietnamese mothers with children aged 2–5 years, which showed that a persuasive feeding style negatively affected children's weight-for-height ratio [30]. In our study, it was observed that as mothers' negative feeding attitudes increased, children's weight decreased, suggesting that maternal attitudes constitute a crucial component of child nutrition and emphasizing the central role of mothers in their children's feeding practices. Therefore, families should be informed about the components of a healthy eating model for children and ways to ensure dietary variety [31]. At the same time, it should be acknowledged that feeding is also an emotional process for mothers, and appropriate support should be provided.

Balanced and healthy nutrition in children is closely related to maternal feeding attitudes. As motherhood represents a new phase in a woman's life beginning with pregnancy, it is essential that mothers receive adequate support and education on all relevant issues, including child nutrition, to ensure the upbringing of healthy future generations.

Conclusion

In this study, the effects of mothers' feeding attitudes on the anthropometric measurements of children aged 2–6 years were examined. Evaluation of the feeding process and maternal attitudes revealed that maternal feeding attitudes had a significant impact on children's weight percentiles. Specifically, as negative maternal feeding attitudes increased, a decrease in children's weight was observed. In particular, the Negative Affect During Meal subscale was found to affect both height and weight. These findings indicate that increasing negative maternal attitudes toward feeding are associated with adverse effects on children's anthropometric measurements. Therefore, mothers' feeding practices should be routinely assessed during primary care follow-up visits. When necessary, nutrition education and guidance should be provided to support the development of healthy feeding behaviors and promote optimal growth in children. Educational programs for mothers are believed to have a positive impact on children's long-term health outcomes.

Ethics Committee Approval: The study was approved by Şişli Hamidiye Etfal Training and Research Hospital Ethics Committee (No: 3563, Date: 24.05.2022).

Use of AI for Writing Assistance: All content, including the text, tables, and figures, was created by the authors.

Peer-review: Externally peer-reviewed.

Authorship Contributions: Concept – G.Z.Ö., M.Ç.; Design – G.Z.Ö., M.Ç.; Supervision – G.Z.Ö., M.Ç., S.Ö.S.; Fundings – G.Z.Ö., M.Ç., S.Ö.S.; Materials – G.Z.Ö., M.Ç., S.Ö.S.; Data collection and/or processing – M.Ç.; Analysis and/or interpretation – G.Z.Ö., M.Ç., S.Ö.S.; Literature search – M.Ç., S.Ö.S.; Writing – M.Ç., S.Ö.S.; Critical review – G.Z.Ö., M.Ç., S.Ö.S.

Conflict of Interest: The authors declare that there is no conflict of interest.

Financial Disclosure: The authors received no financial support for the research, authorship, and/or publication of this article.

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