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Abstract

Objectives: To determine the influence of maternal sensitivity on infant feeding problems in very preterm/very low birth weight (VP/VLBW) and full-term (FT) infants.

Methods: Longitudinal study of 178 infants (73 VP/VLBW and 105 FT). Feeding problems and maternal sensitivity were assessed at term, 3 and 18 months. A cross-lagged path model was tested to assess the longitudinal associations.

Results: The direction of the association between maternal sensitivity and feeding problems differed among VP/VLBW and FT infants. In VP/VLBW infants, higher feeding problems at term and 3 months were associated with less maternal sensitivity at 3 months ($\beta = -0.27, p < 0.05$) and at 18 months ($\beta = -0.36, p < 0.05$), respectively. In FT infants, a reciprocal relationship of feeding problems and maternal sensitivity over time was found. Feeding problems at 3 months were associated with decreased maternal sensitivity at 18 months ($\beta = -0.32, p < 0.05$) while decreased maternal sensitivity at 3 months was related to increased feeding problems at 18 months ($\beta = -0.25, p < 0.05$).

Conclusions: Feeding problems are frequent in VP/VLBW infants and subsequently are associated with maternal sensitivity. In FT infants, decreased maternal sensitivity both resulted from feeding problems but also increased them over time.

Keywords: feeding, maternal sensitivity, preterm birth, infancy.

INTRODUCTION

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Feeding problems are a major concern during infancy and toddlerhood with a prevalence rate of approximately 20% to 30%.¹ The earlier the onset of these problems, the more severe and persistent the consequent eating problems tend to be.² Picky eating or food refusal and oral-motor difficulties such as difficulties in sucking, chewing and/or choking are the most frequent symptoms of feeding problems in infancy.^{3,4} Infant feeding problems are distressing for parents⁵ and observed in the relational context of parent-infant interaction around feeding.⁶ If relational context matters in the development of feeding problems, both parenting behavior and infant characteristics should be involved.⁷ Specifically, maternal sensitivity, indicating awareness of the cues by the infant and appropriate responses to the infant,⁸ have been suggested to either predispose to the development of feeding problems or maintain them.^{9,10}

Parent-infant relationships have most often been studied in those referred for feeding problems.¹¹ The observed maladaptive interactions in such dyads may be the result of the feeding problems^{12,13} and do not allow any conclusions that these have been their precursors. Longitudinal studies identified family factors^{2,14} or maternal negative emotionality¹⁵ as precursors of persisting feeding problems, however, these were all based on parent self-reports rather than direct observations of mother-infant interaction. We are aware of two prospective studies that observed maternal sensitivity and feeding problems over time, one of which revealed no longitudinal influence of maternal sensitivity on feeding problems at 10 months and 2 years of age;¹⁶ the other study showed that maternal mind-mindedness at 6 months, which may predict maternal sensitivity, was related to positive feeding behaviors at 1 year of age.⁹ There is thus a surprising lack of prospective cross-lagged designs to disentangle the currently unclear direction of associations between infant feeding problems and maternal sensitivity over time.

1 were 41 male and 32 female participants with a mean of 29.4 weeks of gestation and 1285.8
2 grams of birth weight (see Table 1 for further details).

3 One hundred and five FT infants (37- 42 weeks gestation) who did not have neonatal
4 medical problems, stratified by socio-economic status, sex and multiple birth were recruited
5 from the same hospitals. There were 60 male and 45 female FT infants in the study.

6 Ethical approval was given by the university and ethical review boards of the
7 participating hospitals. Moreover, informed consents were received from parents.

8 **Measures**

9 **Maternal Sensitivity.** Maternal sensitivity was measured with observational measures at
10 term, 3 months and 18 months corrected age for prematurity. At term, the Boston City
11 Hospital Assessment of Parental Sensitivity (BCHAPS²⁰) was used by neonatal care nurses to
12 rate maternal sensitivity of mothers of VP/VLBW infants based on their observations in the
13 last week. For FT infants, midwives completed the BCHAPS during repeated home visits in
14 the first 10 days of infant's life. The BCHAPS measures how the mother cares for, interacts
15 with and enjoys the relationship with her infant rated on thirteen items with 5-point Likert
16 type scales (1=poor; 5=very competent). An example item was 'mother effectively soothes
17 the baby'. Internal consistency of the scale in the total sample was high (Cronbach's Alpha=
18 .95).

19 At 3 months, maternal sensitivity was measured with a structured play observation:
20 the Mother-Infant Structured Play Assessment (MISPA). The play observation consisted of 2
21 minutes of play with a toy and 2 minutes of free play. Maternal sensitivity was coded using a
22 5-point scale of maternal positive emotion expression, sensitivity and stimulation adapted
23 from three interaction coding schemes: The Emotional Availability Scales (EAS)²¹; The
24 Infant and Caregiver Engagement Phases (ICEP)²²; The Play Observation Scheme and

1 Emotion Ratings (POSER).²³ 20 videotapes were coded by two independent raters. The inter-
 2 rater reliability scores for each item were moderate to high ($\kappa_{\text{positive emotion}} = 0.76$, $\kappa_{\text{sensitivity}} =$
 3 0.76 , $\kappa_{\text{stimulation level}} = 0.78$) and the overall reliability of the maternal sensitivity factor was
 4 moderate ($\alpha_{\text{maternal sensitivity}} = .73$).

5 At 18 months, the Play Observation Scheme and Emotion Rating (POSER) was used
 6 to observe maternal behaviors. POSER includes two play sessions, play with a toy and free
 7 play each lasting 2.5 minutes. The maternal sensitivity factor consisted of maternal positive
 8 emotion expression, sensitivity and appropriateness of play each rated on a 9-point Likert
 9 scale (1: highly insensitive; 9: highly sensitive). 20 videotapes were coded by two trained
 10 independent researchers. Both, inter-rater reliability of each item ($\kappa_{\text{positive emotion}} = .93$,
 11 $\kappa_{\text{sensitivity}} = .90$, $\kappa_{\text{appropriateness of play}} = .91$) and overall reliability of the maternal sensitivity factor
 12 were high ($\alpha_{\text{maternal sensitivity}} = .90$).

13 **Infant Feeding Problems.** Infant feeding problems were assessed via a standard structured
 14 interview (Appendix 2) about feeding problems at term, 3 and 18 months corrected age for
 15 prematurity. Problems in oral-motor functioning were measured with the following three
 16 items: a) stopping after a few sucks, b) excessive dribbling/difficulty swallowing, c)
 17 gagging/choking during the feed. Participants were dichotomized into two groups: no oral-
 18 motor functioning problems (0 or 1 problem present) and oral-motor functioning problems (2
 19 or 3 problems present). Faddy eating/ food refusal was measured with one item (fighting
 20 against the bottle/breast) at term and 3 months. At 18 months, a faddy eating/food refusal
 21 scale was created including the following variables: Eats too little, leaves most of the food
 22 offered, poor appetite, picky eater, slow eater, refuses to eat lumpy food, refuses to eat
 23 puree.²⁴ Internal consistency of this scale was high; Cronbach's Alpha: .80. Participants were
 24 categorized as having faddy eating/food refusal problems if they had 5 or more problems (i.e.
 25 a score $> 75^{\text{th}}$ percentile at 18 months).

1 **Control Variable.** Medical risk was a control variable which was the composite of
2 neurosensory deficits, rehospitalization, surgical procedures, and oxygen dependency
3 assessed from medical notes and interviews at 3 months. Neurosensory deficits were defined
4 as clinically significant deficits in hearing, vision, muscle tone or presence of hydrocephalus.
5 Re-hospitalization was defined as whether the infant was readmitted to a hospital after final
6 discharge from the neonatal unit. Surgical procedures were defined as whether the infant had
7 any major surgery (e.g. for Patent Ductus Arteriosus, Necrotizing Enterocolitis). Lastly,
8 oxygen dependency was defined as oxygen use of more than 21% (1: never, 2: oxygen
9 dependency still at term, 3: oxygen dependency still at 3 months).²⁵ Moreover, family income
10 level (low: £0- £25k, middle: £25k- £40k, high: >£40k) was a control variable.

11 **Statistical Analysis**

12 Preliminary analyses were conducted with SPSS (version 21.0; IBM, Armonk, NY).
13 One-way ANOVA was used to compare maternal sensitivity scores between VP/VLBW and
14 FT samples, and Chi-square test was used to compare the feeding problems between
15 VP/VLBW and FT samples.

16 A cross-lagged panel model²⁶ was used to assess the magnitude and significance of
17 the associations of infant feeding problems on subsequent maternal sensitivity, and the
18 associations of maternal sensitivity on subsequent infant feeding problems. Longitudinal
19 cross-lagged model is a widely used method to assess the reciprocal relationship between two
20 variables, in which the bidirectional associations between the two can be examined while
21 controlling for effects at earlier points in time.

22 Cross-lagged panel analysis was conducted with MPlus (Version 7, Los Angeles,
23 CA)²⁷ using full information maximum likelihood estimation to account for non-normality of
24 the data. Four models (Figure 1) were assessed: 1) an autoregressive model with only

1 autoregressive effects and concurrent correlations between maternal sensitivity and feeding
2 problems but no prospective associations from one construct to the other at a later time point;
3 2) maternal sensitivity unidirectional model which proposes that early differences in maternal
4 sensitivity predict subsequent feeding problems; 3) feeding problems unidirectional model
5 which proposes that difference in early feeding problems predict later maternal sensitivity; 4)
6 reciprocal model which suggests that feeding problems and maternal sensitivity have
7 bidirectional associations with early feeding problems predicting later maternal sensitivity
8 and early maternal sensitivity predicting later feeding problems. Analysis was adjusted for
9 medical risk and income.

10 In order to evaluate the goodness-of-fit, χ^2 tests and the goodness-of-fit indices were
11 considered. Among the various fit indices, incremental fit indices such as Comparative Fit
12 Index (CFI), Tucker Lewis Index (TLI) and Root Mean Square Error of Approximation
13 (RMSEA) ²⁸ were used as they are less sensitive to the impact of sample size. For the CFI
14 and TLI, values greater than .90 show an acceptable fit and values greater than .95 indicate a
15 good fit.²⁹ For the RMSEA, values less than .05 indicate a good fit and values less than .08 an
16 acceptable fit. Moreover, chi-square difference test between the constrained and
17 unconstrained models were conducted in order to test for difference between VP/VLBW and
18 FT models.

19 RESULTS

20 Group Differences in Feeding Problems and Maternal Sensitivity

21 VP/VLBW and FT infants significantly differed from each other on some components
22 of feeding problems (Table 1). At term, VP/VLBW infants (40.3%) had significantly more
23 oral-motor difficulties in comparison to FT infants (18.1%) ($p < .01$), specifically more

1 excessive dribbling/difficulty swallowing (40.3%, $p < .05$), and gagging/choking during feeds
2 (37.5%, $p < .05$). VP/VLBW infants (60.5%) continued to have more gagging/choking during
3 feeds in comparison to FT infants (49.5%) at 18 months ($p < .05$). Additionally, VP/VLBW
4 infants had more faddy eating/food refusal (34.2%, $p < .05$), specifically picky eating (57.8%,
5 $p < .05$), and refusing to eat lumpy food (28.1%, $p < .05$) at 18 months. In contrast, there were
6 no significant mean differences between VP/VLBW and FT infants in maternal sensitivity
7 across the first 18 months.

8 **Differences in the Association between Feeding Problems and Maternal Sensitivity in** 9 **VP/VLBW and FT Infants**

10 Model fit of the four models are shown in Table 2. The reciprocal model showed the
11 best fit to the data in the FT sample (CFI=1.00, TLI=1.00, RMSEA=0.00). In VP/VLBW
12 infants, both the unidirectional model from feeding problems to maternal sensitivity
13 (CFI=1.00, TLI= 1.04, RMSEA=0.00) and reciprocal model (CFI=0.99, TLI= 0.96,
14 RMSEA=0.05) showed good data fit. Chi-square difference tests indicated that the model fit
15 did not differ between VP/VLBW and FT infants.

16 In the VP/VLBW sample, uni-directional cross-lagged path weights from infant
17 feeding problems to maternal sensitivity were significant from term to 3 months ($\beta = -.27$,
18 $p < .05$); and from 3 months to 18 months ($\beta = -.36$, $p < .05$). No reciprocal significant
19 associations from maternal sensitivity to subsequent feeding problems were found at any time
20 point (Figure 2).

21 In contrast, in the FT sample, there was significant reciprocal relationship between
22 maternal sensitivity and feeding problems from 3 months to 18 months of age. Lower
23 maternal sensitivity at 3 months significantly increased infant feeding problems at 18 months

1 ($\beta = -.25, p < .05$). Similar, higher infant feeding problems at 3 months significantly decreased
2 maternal sensitivity at 18 months ($\beta = -.32, p < .05$). Neither infant feeding problems nor
3 maternal sensitivity had significant influences on each other in early infancy from birth to 3
4 months of age (Figure 2).

5 DISCUSSION

6 This study found that VP/VLBW infants had more feeding problems at term and at 18
7 months compared to FT infants. Nevertheless, there were no differences in observed mean
8 maternal sensitivity between FT and VP/VLBW infants at any time. Although the overall
9 models were similar in VP/VLBW and FT infants, the individual significant associations
10 between maternal sensitivity and feeding problems over time varied between VP/VLBW and
11 FT infants. The relationship was reciprocal from 3 months in FT infants; however it was uni-
12 directional in VP/VLBW indicating that feeding problems adversely influenced maternal
13 sensitivity over time.

14 The finding that VP/VLBW infants tend to have feeding problems more often during
15 infancy, in particular oral-motor problems and faddy eating/food refusal, is consistent with
16 previous reports. This might be partly due to early medical complications and adverse oral
17 motor experiences.^{17,18} Furthermore, the finding that mothers of VP/VLBW show, on
18 average, no differences in their sensitivity in interaction compared to FT mothers is also
19 consistent with findings of a recent meta-analysis of thirty-four studies.³⁰

20 The investigation of the association between feeding problems and maternal
21 sensitivity showed that in VP/VLBW infants, low maternal sensitivity was not a predisposing
22 factor for feeding problems across infancy. Rather, when VP/VLBW infants had difficulties
23 in feeding, there was a decline in subsequent maternal sensitivity at the next assessment
24 point, i.e. at 3 months and 18 months, respectively. This finding suggests that mothers of

1 VP/VLBW infants change their parenting behavior since it is the infant characteristics which
2 alter parenting behavior rather than the opposite.

3 In contrast, the relationship between feeding problems and maternal sensitivity was
4 best explained by a reciprocal model in FT infants. Feeding problems at three months
5 decreased subsequent maternal sensitivity at 18 months while lower maternal sensitivity at 3
6 months increased feeding problems at 18 months. This finding supports the suggestion that
7 non-organic feeding problems in healthy infants are manifested in mother-infant interaction
8 problems.⁷ Similar complex relationships have been shown between maternal behavior and
9 infant sleep patterns during early infancy.³¹ The reciprocal relationship between feeding
10 problems and maternal sensitivity in FT infants was apparent between 3 months and 18
11 months of age but not between term and 3 months. This finding is may be consistent with a
12 model of bio-behavioral shift in development from birth to 3 months during which both
13 infants go through substantial changes in biological, cognitive and behavioral domains.³²
14 During this time, parents are also in a process of adaptation and change³³ and individual
15 differences such as in crying behavior are large.³⁴ Thus, the association between feeding
16 problems and maternal sensitivity might be more apparent after the first 3 months in FT
17 infants.

18 Consistent with our findings, it has been suggested that categories of feeding
19 problems (limited appetite, selective intake and fear of feeding) and maternal feeding styles
20 (responsive, controlling, indulgent and neglectful) should be incorporated for a diagnosis of a
21 feeding problem.³⁵ This suggestion was mainly based on maternal behaviors during feeding.
22 Our study extends it as we tested general maternal sensitivity during play rather than during
23 mealtime. Observations of maternal sensitivity during mealtimes are strongly dependent on
24 the infant's feeding behavior while our observations during play provide an independent
25 measure of maternal behavior.¹²

1 There are some strengths and limitations of the study. The main strength of this study
2 is that it assessed maternal sensitivity and feeding problems longitudinally at the same time
3 points which allowed us to use a cross-lagged design. Furthermore, this study measured
4 general maternal sensitivity with observation tasks at each time point rather than focusing on
5 the behaviors during meal time. One limitation of this study is that maternal sensitivity at
6 term was assessed at hospital for VP/VLBW infants while it was assessed at home for FT
7 infants. The nurses knew the VP/VLBW parents for a longer period in the special care unit
8 whereas midwives visited the families of FT infants several times during the first 10 days.
9 Therefore, nurses may be more familiar with parenting of VP/VLBW infants in comparison
10 to FT infants. However, similar significant association between maternal sensitivity at term
11 and 3 months in FT sample as in the VP/VLBW supports the validity of the term assessment
12 in FT sample. Moreover, feeding problems were assessed with a parental report which may
13 be less objective than direct observation or diary recordings.³⁶

14 To conclude, in FT infants without medical complications feeding problems appear to
15 have a reciprocal relationship with maternal sensitivity over time. In VP/VLBW infants, who
16 more often experience feeding problems, the feeding problems tend to decrease maternal
17 sensitivity although mothers of VP/VLBW infants are, on average, not less sensitive. Thus,
18 clinicians should be aware in their diagnosis that the association between feeding problems
19 and maternal sensitivity may differ in dyads of VP/VLBW infants and mothers compared to
20 those of full term healthy dyads. Mothers of VP/VLBW infants with feeding problems at
21 term and mothers of FT infants from 3 months onwards might need more support in dealing
22 with feeding problems to avoid deterioration of mother-infant interaction with potential long
23 term consequences.³⁷

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Figure Legends

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Figure 1. Cross-Lagged Path Model of Maternal Sensitivity and Feeding Problems

Figure 2. Regression Coefficients of Cross-Lagged Path Model of Maternal Sensitivity and Feeding Problems for VP/VLBW and FT infants

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Appendix 1
Participant Flow Diagram