RESEARCH
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"Great Job Cleaning Your Plate Today!" Determinants of Child-Care Providers' Use of Controlling Feeding Practices: An Exploratory Examination

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ABSTRACT

Background National early childhood obesity prevention policies recommend that child-care providers avoid controlling feeding practices (CFP) (eg, pressure-to-eat, food as reward, and praising children for cleaning their plates) with children to prevent unhealthy child eating behaviors and childhood obesity. However, evidence suggests that providers frequently use CFP during mealtimes.

Objective Using the Academy of Nutrition and Dietetics (2011) benchmarks for nutrition in child care as a framework, researchers assessed child-care providers' perspectives regarding their use of mealtime CFP with young children (aged 2 to 5 years).

Design Using a qualitative design, individual, face-to-face, semi-structured interviews were conducted with providers until saturation was reached.

Participants/setting Providers were selected using maximum variation purposive sampling from varying child-care contexts (Head Start, Child and Adult Care Food Program [CACFP]–funded centers, non-CACFP programs). All providers were employed full-time in Head Start or state-licensed center-based child-care programs, cared for children (aged 2 to 5 years), and were directly responsible for serving meals and snacks.

Main outcome measure Child-care providers' perspectives regarding CFP.

Statistical analyses performed Thematic analysis using NVivo (version 9, 2010, QSR International Pty Ltd) to derive themes.

Results Providers' perspectives showed barriers, motivators, and facilitators regarding their use of mealtime CFP. Providers reported barriers to avoiding CFP such as CFP were effective for encouraging desired behaviors, misconceptions that providers were encouraging but not controlling children's eating, and fear of parents' negative reaction if their child did not eat. Providers who did not practice CFP were motivated to avoid CFP because they were unnecessary for encouraging children to eat, and they resulted in negative child outcomes and obesity. Facilitators as an alternative to CFP included practicing healthful feeding practices such as role modeling, peer modeling, and sensory exploration of foods.

Conclusions Training providers about negative child outcomes associated with CFP, children's ability to self-regulate energy intake, and differentiating between controlling and healthful feeding strategies may help providers to avoid CFP.
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THE NECESSITY OF PREVENTING CHILDHOOD OBESITY is widely recognized, and early childhood (ages 2 to 5 years) is a formative period in which to intervene.[1] In conjunction with genetic and ecological factors, children's feeding environment (ie, the "what" and "how" of feeding) shapes their eating behaviors and dietary intake.[2] Child feeding practices that are not responsive to children's internal cues of hunger and fullness can override a child's innate ability to self-regulate energy intake.[3] Nonresponsive or controlling feeding practices (CFP) include pressuring children to eat healthy foods, restricting unhealthy foods, praising

children for finishing their food (clean plate), and offering energy-dense foods as a reward for consuming nutrient-dense foods.[4,5] These CFP have been associated with negative child outcomes such as increased consumption of sugar-sweetened beverages, palatable snack foods, and calorie-dense food items[6]; lowered self-regulation of caloric intake[7-10]; increased food refusals[11]; and childhood obesity.[12-15] Conversely, using responsive or healthful feeding practices (HFP), in which the adult caregiver allows the child to decide what and how much she or he eats, gently encourages the child to try foods by modeling healthy eating and provides repeated exposure to novel foods; it also supports children's self-regulation of energy intake[3,16] and acceptance of new foods.[17,18]

Drawing from the aforementioned evidence, national policies for early childhood obesity prevention recommend that child-care providers avoid CFP and use HFP.[19-22] Young children consume approximately half to three-quarters of their daily energy intake while in a full-time child-care program,[23] and child-care providers' mealtime feeding practices are associated with children's dietary intake.[18,24,25] Therefore, providers' feeding practices are important in shaping children's dietary intake and eating behaviors and in reducing their risk for obesity.[26] The Position Paper of the Academy of Nutrition and Dietetics (Academy) benchmarks for nutrition in child care targets children aged 2 to 5 years and recommends that child-care providers use HFP and avoid CFP to promote children's optimal growth and development.[20]

Despite the recommendations for avoiding CFP because of negative outcomes related to eating and weight,[9,27-29] child-care providers frequently use CFP with children.[30-32] In examining compliance to the Academy's benchmarks, child-care providers from all contexts (Head Start, Child and Adult Care Food Program [CACFP]-funded, and nonfunded centers) reported using significantly more controlling mealtime verbal comments than responsive comments.[33] Research is needed to understand this disconnect between recommendations and the practice of CFP in child care. The current study, a subsample from this larger quantitative study,[33] is a follow-up qualitative investigation to explore the child-care providers' perspectives regarding the underlying determinants that may influence them to practice CFP. Given that providers' perspectives predict their feeding practices,[34-36] examining providers' perspectives regarding their use of CFP during child-care mealtimes is a step toward improving their feeding practices. Using the Academy's benchmarks as a framework, the objective of the study is to examine child-care providers' perspectives regarding their use of controlling mealtime feeding practices with young children (aged 2 to 5 years) in their care.

METHODS

Research Design

In-depth, face-to-face, semi-structured interviews were conducted with child-care providers. An interdisciplinary research team (nutrition, child development, child care, and qualitative methods) designed and conducted the study. The University of Illinois at Urbana Champaign Institutional Review Board approved the study methods. A detailed description of the methodology and interview protocol has been previously published.[33,34]

Sampling and Recruitment

Participants were randomly selected from a sampling frame of 90 providers from 24 state-licensed center-based child-care programs,[12] using maximum-variation purposive sampling, to allow a balanced perspective from varying child-care contexts (Head Start, CACFP-funded, and non-CACFP programs).[37] All providers had participated in a larger survey study, were full-time child-care teachers responsible for supervising meals or snacks for 2- to 5-year-old children, and had provided written consent to participate in the interviews if contacted.[33] All providers who were contacted agreed to participate in an interview. Participants received a $25 gift card.

Interview Protocol

A semi-structured interview guide from the About Feeding Children Study[30,38] was used to examine providers' perspectives regarding avoiding CFP. CFP were defined based on the recommendations from the Academy of Nutrition and Dietetics[20] and outlined in the *Head Start Performance Standards*[19]: a) children are not pressured to eat; b) providers do not praise children for finishing food or cleaning their plates; c) food is not used as punishment or reward; and d) each child is encouraged, but not forced, to eat or taste his or her food. Before data collection, the interdisciplinary research team reviewed the interview protocol, and the lead author (interviewer) completed training on strategies to remain open, unbiased, and nonjudgmental during the interview.[39] The lead author pilot tested the interview protocol for face validity with seven child-care providers.[39]

Data Collection

The lead author, who had no prior relationship with the child-care programs or providers, conducted one-on-one, face-to-face interviews with child-care providers until data saturation was reached (ie, additional interviews did not reveal new relevant information).[40] One-on-one interviews were conducted between August and November 2012 at the participants' center, in a quiet, unoccupied room.[39] Each interview lasted 45 to 60 minutes; each was audio recorded, and field notes were taken. Pseudonyms were used for all child-care providers to maintain confidentiality.

Data Analysis

All interviews were transcribed verbatim by a professional transcription agency and imported into NVivo (version 9, 2010, QSR International Pty Ltd) for analysis.[41] Data analysis followed the six steps for thematic analysis outlined by Braun and Clarke[42]: familiarizing with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report. Categories and themes were further reviewed for validity, to crosswalk the data to identify common elements from and draw overarching themes from the entire data.[43]

The first and third authors independently read each transcript twice and identified a set of codes, code definitions, and themes. These coders then met to achieve consensus about codes and themes.[44] If disagreement occurred, the two coders modified and refined the coding and themes until any disagreements were resolved. Members of the research team who did not code the transcripts verified that the codes and