

The Pediatric Eating Assessment Tool: Factor Structure and Psychometric Properties

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ABSTRACT

Objectives: The Pediatric Eating Assessment Tool (PediEAT) is a parent-report instrument developed to assess symptoms of feeding problems in children aged 6 months to 7 years. The purpose of this study was to identify the factor structure of the PediEAT and test its psychometric properties, including internal consistency reliability, temporal stability, and construct validity.

Methods: Participants included 567 parents of children aged 6 months to 7 years. Fifty-four percent of the sample had parent report of a diagnosed feeding problem or feeding concerns. Exploratory factor-analysis techniques were used to remove redundant or non-endorsed items and identify the factor structure of the instrument. Construct validity was examined with 466 parents completing the Mealtime Behavior Questionnaire as a criterion standard. Known-groups validation was used to compare PediEAT scores between children with and without diagnosed feeding problems. Temporal stability of the PediEAT was examined with 97 parents repeating the PediEAT after 2 weeks.

Results: Principal components factor analysis with varimax rotation supported a 4-factor model accounting for 39.4% of the total variance. The 4 subscales (Physiologic Symptoms, Problematic Mealtime Behaviors, Selective/Restrictive Eating, Oral Processing) demonstrated acceptable internal consistencies (coefficient alphas: 0.92, 0.91, 0.83, 0.83; respectively). Construct validity was supported in 2 ways. The PediEAT correlated with the Mealtime Behavior Questionnaire ($r = 0.77$, $P < 0.001$) and total score and subscale scores were significantly different between children with and without diagnosed feeding problem ($P < 0.001$). Temporal stability was demonstrated through test-retest reliability ($r = 0.95$, $P < 0.001$).

Conclusions: Strong psychometric properties support the use of the PediEAT in research and clinical practice.

Key Words: feeding behaviors, feeding difficulties, feeding problems, measurement, psychometric

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What Is Known

- Difficulties with eating are common among infants and young children.
- Determining if a feeding problem is significant can be challenging.
- Feeding problem measures primarily focus on behavioral indicators.

What Is New

- The Pediatric Eating Assessment Tool examines observable physiologic and behavioral symptoms of feeding problems.
- The Pediatric Eating Assessment Tool can be used from an early age 6 months through age 7 years.
- The Pediatric Eating Assessment Tool is a valid and reliable measure for research and clinical practice.

Feeding problems during infancy and early childhood are prevalent and rising in number due to increased survival of infants with extreme prematurity (1) and medical complexity (2), and a growing population of children with developmental disabilities, such as autism spectrum disorder (3,4). Although we are in need of robust epidemiological studies, up to 20% of typically developing children, 80% of children with developmental disabilities, and 85% of children with complex medical conditions are reported to experience feeding difficulties (5–8). Pediatric feeding problems are a clinical problem of high impact because disruption in child feeding is associated with negative effects on child social, emotional, physical, and cognitive development, and significantly impacts parent well-being and family life (5,9,10). As such, adequate assessment of symptoms of a feeding problem is necessary to determine need for referral, select appropriate treatments, and monitor treatment effectiveness.

The Pediatric Eating Assessment Tool (PediEAT) was developed to assess symptoms of a feeding problem by parent report in young children aged 6 months to 7 years who have begun to eat solid foods. Symptoms are conceptualized as observable behaviors and biologic function related to food, eating, or mealtime. Content validity of the PediEAT has been established (11). This study aimed to identify the factor structure of the PediEAT and test its psychometric properties, including internal consistency reliability, temporal stability, and construct validity.

METHODS

Setting and Sample

The participants in this study were parents or caregivers (hereafter referred to as “parents”) of young children with and without feeding problems. To participate, parents had to be 18 years of age or older, caring for a 6 month to 7-year-old child being offered at least some solid foods, and self-report as being literate in English. The institutional review board of the University of North Carolina at Chapel Hill approved the study.

Quota sampling was used to ensure an equal distribution of parents of children across the age categories between 6 months and 7 years on the American Academy of Pediatrics (AAP) periodicity schedule (12). We also aimed to over-represent the sample with parents of children with feeding problems to capture a thorough representation of feeding problem symptoms. Parents of children with feeding problems, or at-risk for feeding problems, were recruited from a feeding specialty clinic in NC, researchmatch.org, and several on-line support groups for parents of children with feeding difficulties. Concurrently, parents of children without feeding problems were recruited from parent support groups in NC and MA, research volunteers at the University of North Carolina’s Join the Conquest registry, and from a general e-mail invite to University staff, students, and faculty. All parents were asked to report on a single child.

Measures

Pediatric Eating Assessment Tool

The Pediatric Eating Assessment Tool (PediEAT) measures symptoms of feeding problems in young children. Content validity was established using DeVellis’ methods of scale development (13) through systematic item generation and evaluation by clinical and research experts as well as by the intended respondents: parents of children both with and without feeding problems. A full description of these processes is available in a previous publication (11). The readability of the PediEAT was tested throughout the content validation process with adjustments made so that the final version was written at a less than fifth grade reading level. The final PediEAT included a comprehensive set of 97 symptoms describing the difficulties parents observe directly during mealtime (eg, refusal, volume limiting) and symptoms they observe to be concurrent with feeding difficulties (eg, arching, constipation, fatigue). Items are worded in both the positive and negative necessitating reverse scoring of some items. All items begin with the prefix *My child*. . . ; respondents are directed to “think about what is typical for your child at this time” and to select from 6 response options for each item (Never, Almost Never, Sometimes, Often, Almost Always, Always).

Mealtime Behavior Questionnaire

To assess construct validity, we evaluated the PediEAT alongside a previously established measure, the Mealtime Behavior Questionnaire (MBQ) (14). The MBQ measures problematic behaviors during mealtime of young children aged 2 to 6 years with 33 items that were factored with a community sample. The 4 subscales (Food Refusal/Avoidance, Food Manipulation, Mealtime Aggression/Distress, and Choking/Gaging/Vomiting) had internal consistencies ranging from 0.76 to 0.89. Parents are asked to “. . . rate each behavior as it occurred during mealtimes or feeding over the past week” (p. 145) (14) and to select from 5 response options for each item, with 3 options provided representing the tails and center (Never, Sometimes, Always).

Procedures

Before the study, the on-line survey was developed and piloted with 19 parents using various devices (smart phone, tablet, laptop, or desktop computer). Feedback was elicited on survey utilization to which parents responded positively; no adjustments were needed. For the study, parents were invited to complete the PediEAT, the MBQ and a set of questions to describe parent and child demographics, child health, and feeding history. Following completion, parents were offered a gift card and the same parent was invited to repeat the PediEAT 2 weeks later to evaluate its temporal stability. This interval between tests is commonly selected for questionnaires measuring phenomenon that are expected to be relatively stable across a short period yet sufficient in length to preclude the respondent from remembering prior answers (15,16). Once a minimum of 20% of the targeted sample size completed the retest (ie, $n \geq 97$), invitations to repeat the PediEAT ended. This consecutive sampling plan introduced randomness to the retest sample and assured that the size of the test-retest sample exceeded that which is recommended (16).

Data were analyzed using SPSS Statistics, Version 24.0 (IBM Corp, Armonk, NY). All cases with more than 10% of missing data on the PediEAT or MBQ were excluded from the analysis.

RESULTS

A total of 613 parents from a wide geographic area across the United States and Europe completed the survey. After removal of missing case data, the final sample included 567 parents. Thirty-four percent of the sample reported the target child had a diagnosed feeding problem; an additional 20% reported the child either had a feeding problem or they were unsure if the child had a feeding problem. The target children represented all 11 age categories of the AAP periodicity schedule from 6 months to 7 years of age (12), with equal distributions from 6 months to 2 years ($n = 189$), 2 to 4 years ($n = 187$), and 4 to 7 years ($n = 191$). Children were 55% boys, 12.7% used a feeding tube for supplemental feeding, and 23.4% were reported to be developmentally delayed. Respondent’s income and education level varied, with 22.4% of the sample below US median household income. Educational attainment of the sample was higher than the US national average (17). Table 1 provides frequencies of the target children by age group and sex. Table 2 provides descriptive statistics of the parent respondents and target children.

TABLE 1. Summary of number of target children by age and sex

	Sex		Total
	Male	Female	
Age			
6–9 months	9	13	22
9–12 months	15	10	25
12–15 months	29	15	44
15–18 months	17	19	36
18–24 months	35	27	62
24–30 months	27	32	59
30–36 months	24	21	45
3–4 years	49	34	83
4–5 years	34	34	68
5–6 years	36	21	57
6–7 years	37	29	66
Total	312	255	567

TABLE 2. Descriptive statistics for respondents and target children (n = 567)

Variable	Frequency
Relationship to Child	
Mother	95.2%
Father	3.9%
Other	0.9%
Race (n = 564)	
White	84.4%
Black	4.4%
Multi-racial	4.1%
Asian	3.7%
Hispanic	2.7%
Other	0.7%
Household Income (n = 559)	
<\$20,000	4.1%
\$20–\$39,999	12.3%
\$40–59,999	11.6%
\$60–79,999	17.7%
\$80–99,999	16.1%
>\$100,000	38.1%
Education	
High School degree or less	9.2%
Technical School/Community College	11.3%
College/University	79.5%
Family Type	
Two-parent	90.3%
Single-parent	7.6%
Other	2.1%
Parent reports child has feeding problem	
Yes	42.0%
Unsure	12.7%
No	45.3%
Diagnosed feeding problem*	34.4%
Currently supplements with feeding tube	12.7%
Child has seen a professional in the past 6 months for feeding issues	41.1%
Select child conditions [†]	
History of prematurity [‡]	25.0%
Developmental delay [§]	23.4%
Sensory processing disorder	13.6%
Genetic disorder	10.7%
Congenital heart disease	9.8%
Cerebral palsy	7.0%
Autism spectrum disorder	5.5%

*n = 544; [†]more than one condition could be selected; n = [‡]556, [§]561, ^{||}543.

Item Analysis

Descriptive statistics and item-total and inter-item correlations (*r*, Pearson's product-moment correlation) were calculated for each of the items. No single PediEAT item was identified as having more than 10% missing data so all were retained. Seven items were removed from further analysis due to correlations of >0.8 (3 items) or <0.3 (4 items). All remaining items correlated at least moderately with other items. The Kaiser-Meyer-Olkin statistic was 0.914, indicating an adequate sample size (18) and the Bartlett test of sphericity was statistically significant ($\chi^2 = 22,525.97$, $P = 0.000$), indicating the sample was suitable for factoring (19).

Factor Analysis

An exploratory factor analysis was run on the remaining 90 items using principal components analysis with varimax rotation. Examination of the scree plot revealed that a 4- to 7-factor solution would appropriately represent the data. We systematically tested a 7-, 6-, 5-, and 4-factor solution, each time examining the total variance explained, the added variance explained by the addition of a higher number of factors, cross-loading of items, and the conceptual clarity of the derived factors. Through a process of eliminating 1 item at a time based on communalities, and re-examining the factor solutions, it was determined that a 4-factor structure, with 83 items, was the best solution. We then conducted a conceptual analysis of each item within each of the 4 factors to determine placement of cross-loaded items and elimination of items with low loadings. This process led to movement of 3 items from 1 factor to a cross-loaded factor, and deletion of a total of 5 items. All remaining items loaded above 0.33. The final 4 factors, with a total of 78 items, explained 39.4% of the total variance; factor loadings for the rotated solution are displayed in Table 3.

Factor 1 contains 27 items representing physiologic symptoms related to eating or mealtime, such as breathes faster or harder when eating, arches back during or after meals, and throws up during mealtime. Factor 2 contains 23 items representing problematic mealtime behaviors, such as insists of being fed by the same person, becomes upset by the smell of food, and refuses to eat. Factor 3 contains 15 items representing selective/restrictive eating, such as will eat mixed textured food, will eat foods that need to be chewed, and will eat frozen food, like ice cream. Factor 4 contains 13 items representing oral processing, such as puts too much food in mouth at 1 time, has to be reminded to chew, and prefers smooth foods like yogurt.

Internal Consistency Reliability

Cronbach's coefficient alpha (α) was used to assess internal consistency reliability of the total PediEAT and the subscales. The total PediEAT had excellent internal consistency ($\alpha = 0.95$) and the 4 subscales had excellent to good internal consistencies ($\alpha = 0.92$, 0.91, 0.84, 0.84; respectively).

All factors, hereafter called subscales, and total PediEAT scores were significantly correlated ($r = 0.70$ – 0.83 , $P < 0.001$). The Physiologic Symptoms subscale was most strongly correlated with the total score. Moderate positive correlations existed between the subscale scores ($r = 0.32$ – 0.61 , $P < 0.001$); Physiologic Symptoms was most related to Selective/Restrictive Eating; Problematic Mealtime Behaviors was least related to Oral Processing.

Construct Validity

The PediEAT total scores were strongly related to the MBQ total scores ($r = 0.77$, $P < 0.001$, $n = 466$), establishing construct validity. The PediEAT subscale scores were moderately to strongly related to the MBQ total scores ($r = 0.46$ – 0.77 , $P < 0.001$) with the Problematic Mealtime Behaviors subscale of the PediEAT most strongly related to the MBQ total scores. Weak to strong positive correlations existed between the PediEAT and the MBQ subscale scores ($r = 0.26$ – 0.81 , $P < 0.001$).

Total PediEAT and subscale scores were compared for a subset of the sample with and without feeding problems using independent-samples *t* tests. For this "known groups" validity analysis, the feeding problem group was defined as parent-report of child having a diagnosed feeding problem ($n = 187$). The no feeding problem group was defined as parent report of no feeding problem, no diagnosed feeding problem, no use of feeding services

TABLE 3. Factor loadings for principal component analysis with varimax rotation of the Pediatric Eating Assessment Tool Scales

Subscale	Pediatric Eating Assessment Tool Items	Factor loadings
Physiologic symptoms; 27 items; Cronbach's α 0.92	Gets watery eyes when eating	0.71
	Gets red color around eyes or face when eating	0.65
	Gets pale or blue color around his/her lips during meals	0.64
	Coughs during or after eating	0.63
	Sounds gurgly or like they need to cough or clear their throat during or after eating	0.62
	Breathes faster or harder when eating	0.60
	Throws up between meals (from 30 minutes after the last meal until the next meal)	0.59
	Sounds different during or after a meal (eg, voice becomes hoarse, high-pitched, or quiet)	0.59
	Needs to take a break during the meal to rest or catch their breath	0.58
	Sweats/gets clammy during meals	0.58
	Arches back during or after meals	0.56
	Throws up during mealtime	0.56
	Gags when it is time to eat (eg, when they see food or when placed in high chair)	0.55
	Burps more than usual while eating	0.55
	Moves head down toward chest when swallowing	0.55
	Has food or liquid come out of nose when eating	0.53
	Gags with smooth foods like pudding	0.53
	Tilts head back while eating	0.50
	Chokes or coughs on water or other thin liquids	0.48
	Gags, coughs, or vomits when brushing teeth	0.47
	Gets a bloated tummy after eating	0.45
	Drools when eating	0.41
	Has a hard time eating due to stuffy nose	0.41
	Turns red in face, may cry with stooling	0.40
	Gags with textured food like coarse oatmeal	0.40
	Gets tired from eating and is not able to finish	0.39
	Has gas	0.33
Problematic mealtime behaviors; 23 items; Cronbach's α 0.91	Avoids eating by playing or talking	0.78
	Has to be reminded to keep eating	0.74
	Stops eating after a few bites	0.70
	Won't eat at meals, but wants food later	0.70
	Has to be told to start eating	0.68
	Likes to eat	0.67
	Refuses to eat	0.63
	Shows more stress during meals than during non-meal times (whines, cries, gets angry, tantrums)	0.63
	Eats a variety of foods (fruits, vegetables, proteins, etc)	0.56
	Is willing to stay seated during mealtime	0.55
	Likes something 1 day and not the next	0.55
	Insists on food being offered in a certain way (such as, how food is on the plate or what dish or spoon is used, or where they sit)	0.53
	Becomes upset by the smell of food	0.50
	Opens their mouth when food is offered	0.49
	Throws food or pushes food away	0.47
	Prefers to drink instead of eat	0.47
	Eats better when entertained	0.41
	Takes more than 30 minutes to eat	0.40
	Prefers crunchy foods	0.39
	Insists on being fed by the same person (s)	0.38
	Is willing to touch food with their hands	0.37
	Needs mealtime to be calm	0.36
	Wants the same food for more than 2 weeks in a row	0.36
Selective/restrictive eating; 15 items; Cronbach's α 0.84	Will eat foods that need to be chewed	0.78
	Will eat mixed textured foods	0.64
	Is willing to feed self (if younger in age, holds cup, feeds self-crackers)	0.64
	Chews their food enough	0.59
	Will eat frozen food, like ice cream	0.56
	Will eat textured food like coarse oatmeal	0.55
	Moves food in their mouth for chewing without help	0.55
	Keeps food in mouth when eating (food means non-liquids)	0.54
	Keeps liquids in mouth when drinking	0.50
	Keeps their tongue inside mouth during eating	0.49

TABLE 3. (Continued)

Subscale	Pediatric Eating Assessment Tool Items	Factor loadings
Oral Processing; 13 items; Cronbach's α 0.84	Will eat food warmer than room temperature	0.48
	Acts hungry before meals	0.47
	Sniffs food or objects	0.42
	Eats too fast	0.39
	Spits food out	0.38
	Stores food in their cheek or roof of mouth	0.67
	Has to be reminded to chew food	0.65
	Gets food stuck in their cheek or roof of mouth	0.63
	Sucks on food to soften or moisten it, rather than chewing it	0.62
	Puts too much food in mouth at 1 time	0.53
	Chews food but does not swallow it	0.49
	Prefers smooth foods like yogurt	0.49
	Puts fingers in mouth to move food	0.41
	Prefers strong flavors	0.40
	Bites down on the spoon or fork and does not release it easily	0.39
	Chews on toys, clothes or other objects	0.39
Chews a bite of food for a long time (~30 seconds or longer)	0.38	
Grinds teeth when awake	0.34	

in the past 6 months, and no use of a feeding tube ($n=220$). Total PediEAT scores were significantly higher (ie, more feeding problem symptoms) for the diagnosed feeding problem group ($M=135.3$, $SD=38.4$) compared with the no feeding problem group ($M=72.7$, $SD=26.5$); $t(322)=18.79$, $P<0.001$. Levene's test indicated unequal variances ($F=23.56$, $P<0.001$), so degrees of freedom were adjusted from 405 to 322. All 4 PediEAT subscale scores were also significantly higher for children with a diagnosed feeding problem from those without, $P<0.001$; degrees of freedom were adjusted for all tests (Fig. 1). We examined differences between the 2 groups in categories of income, education and selected child conditions using the non-parametric Mann-Whitney U test. Income level was greater for the no feeding problem group ($Mdn=\$80-99,999/\text{year}$) compared with the feeding problem group ($Mdn=\$60-79,999/\text{year}$), $U=15229$, $P<0.001$. Education level was also greater for the no feeding problem group ($Mdn=\text{Technical School/Community College}$ for both groups), $U=17,688$, $P=0.001$. All child health conditions occurred significantly more often in the feeding problem group compared with the no feeding problem group ($P<0.001$): 37.6% versus 13.2% prematurity, 50.5% versus 1.8% developmental delay, 27.4% versus 0.9% sensory processing disorder, 26.9% versus 1.4% genetic disorder, 20% versus 3.6% congenital heart disease, 12% versus 2.7% cerebral palsy, and 8.6% versus 0.9% autism spectrum disorder.

Temporal Stability

The PediEAT's total and subscales scores at baseline and 2 weeks later were strongly correlated ($r=0.87-0.95$, $P<0.001$, $n=97$), demonstrating good to excellent test-retest reliability.

DISCUSSION

The PediEAT has been systematically developed and content validated to measure a broad range of behavioral and physiologic symptoms of feeding problems in young children aged 6 months to 7 years who are eating at least some solid foods (13). The PediEAT is a parent-report instrument, recognizing that parents are the most ecologically valid reporters of their child's day-to-day symptoms.

In this study, the factor structure of the PediEAT was examined with an adequate size sample of parents caring for children with and without feeding problems. Target children were distributed across the intended age ranges of the instrument and over-represented by children with parent report of feeding problems, thereby increasing the likelihood of characterizing a wide range of feeding symptoms. For those with reported feeding difficulties, the severity varied; 12.7% of parents reported their child required supplemental tube feedings while an equal percent reported being unsure of whether their child had a feeding problem. The children with parent report of diagnosed feeding problems had a variety of conditions, with one-half reported as developmentally delayed. This is similar to Berlin et al's feeding clinic sample (20). The wide range of characteristics of the target children strengthens the validity of the factor analysis and supports the relevance of the PediEAT across many clinical populations.

The PediEAT's factor solution was derived through an iterative process of principal components analysis resulting in 78 items represented by 4 subscales: Physiologic Symptoms, Problematic Mealtime Behaviors, Selective/Restrictive Eating, and Oral Processing. Based on the time to complete the 97-item retest of the PediEAT, we estimate the 78-item version would take 10 to 12 minutes to complete.

The Physiologic Symptoms subscale was the largest factor with 27 items and explained the greatest amount of the variance (22.2%) of the 4 subscales. Adding physiologic symptoms to feeding assessment is unique among feeding assessment instruments. Symptoms of gastroesophageal reflux, abdominal distention, vomiting, and constipation have been found to be associated with selective eating, food refusal, dysphasia, lower caloric intake, and/or delayed feeding skills (21-24). With the exception of the MBQ's 3-item Choking/Gagging/Vomiting subscale and 2 similar items on the Toddler Refusal-Texture subscale of the Behavioral Pediatric Feeding Assessment Scale (25), feeding assessment instruments with adequate psychometric properties have primarily focused on behavioral symptoms of feeding problems with little to no attention to physiologic constraints on eating. The PediEAT's physiologic symptoms subscale increases the comprehensiveness of feeding assessment.

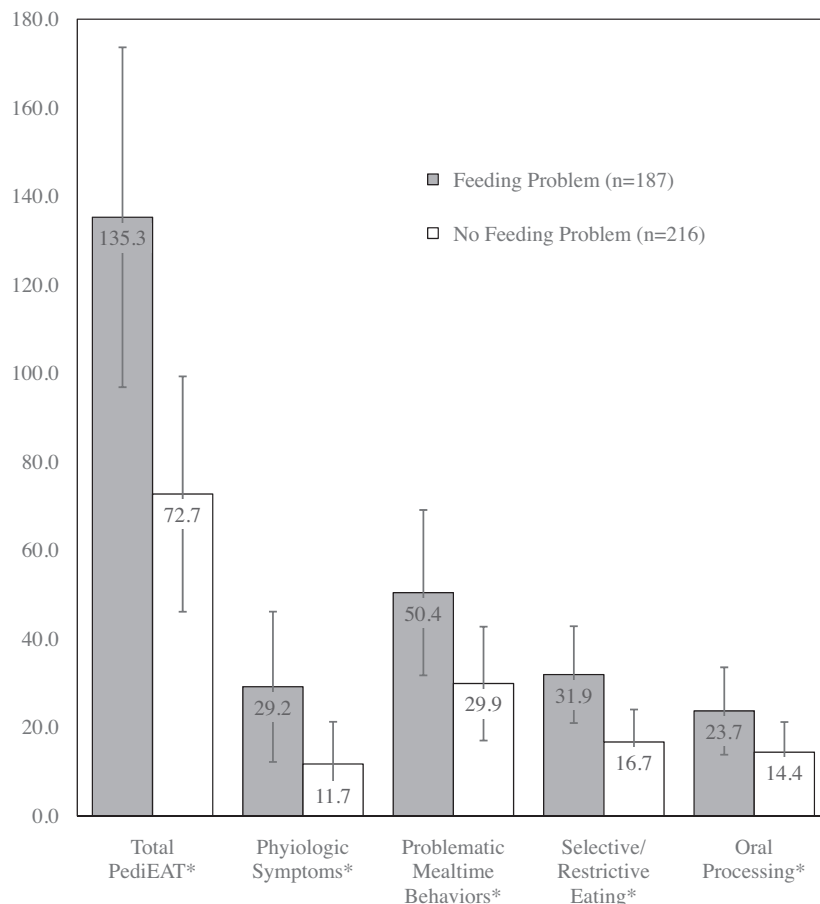


FIGURE 1. Comparison of Pediatric Eating Assessment Tool (PediEAT) Total and Subscale scores of children with and without parent-reported diagnosed feeding problems. Error bars represent 1 standard deviation. **P* < .001.

The PediEAT is valid for children as young as 6 months of age and has now been tested through the age of 7 years. Few instruments assessing symptoms of feeding problems have been validated for children between 6 and 24-months of age. Identifying feeding problems early, before the establishment of avoidant behavioral patterns is necessary for selection of interventions that are optimally timed and targeted to underlying problems. The 6- to 18-month-age period is particularly critical for assessment of the child’s transition to foods that increase in taste and texture complexity as this process contributes to oral motor skill development (26,27), and when delayed, has been found to be associated with more feeding problems (28,29). Several studies retrospectively report early onset of feeding problems with samples derived from feeding specialty clinics. Rommel et al (30) reported 50% of their sample presented with feeding problems before 1 year of age and Williams et al (31) reported 75% of their sample had onset of the feeding problem before 18 months of age. Meyer et al (24) reported the median age of onset of symptoms of food protein-induced gastrointestinal allergies was 5 months, whereas first appointment to a specialist was at a median age of 5 years. Feeding problems were reported by 40% of these parents and were documented in the medical records of 30%, with significantly more early physiologic symptoms of bloating, vomiting, rectal bleeding, and constipation associated with feeding problems. They suggested poor recognition of significant early symptoms contributed to the delay in referral for specialist care.

Limitations

Parent report of child feeding diagnosis, used to define the feeding problem group in the known group validation analysis, was not confirmed by medical record. Therefore, caution is required in interpreting the group data. More research is needed to examine the sensitivity and specificity of the PediEAT in identifying children with and without feeding problems. Of note, children with diagnosed feeding problems were more likely to live in homes with lower income and less educated parents. Parents of children with feeding problems have identified significant family consequences of pediatric feeding problems that deserve more attention. Limited access to competent feeders in child care settings and inability of children to eat adequately outside the home has negative consequences for parental work or pursuit of higher education (32). More is to be learned about how to best support families with children with feeding problems.

Further research is also needed to examine the impact of child age on the symptom profiles of young children with feeding problems. Given the normative age for the development of chewing begins at a mean age of 9 months (33), a limitation of the PediEAT at present is lack of sensitivity of the scoring system to expected differences in scoring at the lower age range. To address this, norm referencing with typically developing children without feeding problems is underway to examine the performance of individual items across the ages of 6 months to 7 years. Norm referencing will

establish cut points for normative subscale scores by age, thereby strengthening the interpretation of the PediEAT scores. A companion tool developed for the newborn age through 6 months, the Neonatal Eating Assessment Tool (NeoEAT), has been content validated (34); the factor analysis and norm referencing will be available soon. Together, the NeoEAT and PediEAT will allow tracking of feeding difficulties from birth through age 7 with a consistently developed set of tools.

CONCLUSIONS

The PediEAT is a valid and reliable instrument for assessment of feeding problem symptoms of children aged 6 months to 7 years. As such, it can aid in the identification and quantification of feeding problems in young children. In earlier studies, the PediEAT's content was comprehensively validated with all potential users, thereby creating a strong platform for further psychometric evaluation (11). In this study, we have validated the factor structure of the PediEAT, identifying 4 subscales for future use. We have demonstrated that the PediEAT scores correlate with scores of a criterion measure, and that PediEAT scores were significantly different between children with parent report of a diagnosed feeding problem compared with those without parent concern or diagnosis. Finally, evidence of the PediEAT's internal reliability and temporal stability was presented. Norm referencing of the PediEAT will further strengthen its future utility.

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