## Introduction

This tutorial provides a structured, hands-on introduction to developing predictive machine learning models for childhood obesity using structured pediatric health data. It is intended as a companion to the guidelines paper, “A Primer for Machine Learning Applications in Childhood Obesity,” and demonstrates how key modeling decisions outlined in the main paper can be applied in practice. The focus is on translating conceptual recommendations into concrete, executable steps, designed to support researchers and clinicians who may not have prior experience with machine learning.

The dataset used in this tutorial is a synthesized version based on the Food and Brain Study ([www.clinicaltrials.gov](http://www.clinicaltrials.gov) : NCT03341247). While modeled on real longitudinal pediatric data, it has been generated to reflect realistic measurement complexity and missingness patterns while preserving participant anonymity. It includes individual and caregiver-reported features covering eating behavior, physical activity, psychological traits, and anthropometry, with a follow-up BMI percentile collected approximately one year later.

This tutorial is designed primarily as an educational exercise. It prioritizes conceptual understanding of modeling logic and decision-making over achieving optimal predictive performance. Users are guided through the end-to-end ML pipeline (including missing data handling, age-sensitive feature engineering, sex-stratified data splitting, model training, and interpretation) with explicit attention to the developmental and measurement challenges unique to child health data. The tutorial emphasizes how and why each step matters, particularly when working with caregiver-reported, behaviorally rich, and developmentally variable inputs.

The modeling approach aligns with a socio-ecological framework, focusing on proximal influences on child weight gain at the individual and family levels. Compared to adult health data, modeling pediatric outcomes requires special attention to age-linked variation, proxy-reported data, and smaller sample sizes. These considerations are addressed throughout the tutorial, with explanations provided for how they inform model design, data preprocessing, and interpretation.

Finally, while the dataset and code presented here are intended to support learning and reproducibility, they are not intended for clinical deployment. The models trained are based on synthesized data and are meant to illustrate methodological principles rather than provide deployable prediction tools. By the end of the tutorial, users will understand how to structure a pediatric ML pipeline, apply child-specific modeling decisions, and interpret outputs with an awareness of both methodological and developmental constraints.

## Why This Tutorial?

### 1. Educational Purpose

This tutorial was created to meet the needs of pediatric health researchers and clinicians who are beginning to explore the use of ML in their work but may lack technical training. It uses realistic pediatric data to guide users through practical decisions required to develop a working predictive model. All code and workflow steps are explicitly paired with explanations of why each modeling decision matters, particularly in pediatric datasets where developmental variability and proxy-reported data introduce complexity.

The tutorial introduces key preprocessing tasks such as outlier handling, variable-specific imputation, and feature engineering that are often overlooked in general ML tutorials. Feature selection is demonstrated using methods such as Recursive Feature Elimination (RFE), which help reduce overfitting in datasets with many correlated behavioral predictors. Special attention is given to strategies that reflect common constraints in pediatric datasets, including modest sample sizes, non-random missingness, and multiple sources of measurement noise.

### 2. Addressing Research Gaps

Many existing ML models in pediatric obesity rely narrowly on demographic and anthropometric predictors, often excluding behavioral and caregiver-reported variables due to complexity or concerns about data quality. This tutorial directly addresses those limitations by including behaviorally rich features and demonstrating how they can be prepared for ML applications.

In addition, the tutorial introduces modeling decisions such as sex-stratified data splitting to account for known biological and behavioral differences in obesity development. These decisions reflect real-world considerations for pediatric researchers and clinicians, and they are grounded in the challenges outlined in the companion review paper.

### 3. Practical Considerations

The tutorial makes use of synthesized data and is not designed for real-world prediction or clinical use. It is intended solely as a reproducible teaching tool. The pipeline, code, and rationale for each modeling step are designed to build transferable skills and improve understanding of how to approach ML in child health contexts.

Although modeled on a specific pediatric cohort, the approaches illustrated here are applicable to other childhood obesity datasets that include behavioral, psychological, or family-level data.

## Who Is This For?

This tutorial is intended for pediatric health researchers, clinicians, graduate students, and public health professionals who are beginning to apply ML methods in childhood obesity studies. No prior experience with ML frameworks is assumed, though a basic understanding of Python and structured data analysis will be helpful. The goal is to provide an accessible yet rigorous example of how structured ML modeling can be applied to developmentally sensitive health data.

### How to Use This Tutorial

Each section of the tutorial is organized around a real-world task in model development, with paired code and explanation. Key tasks include:

* Data structure review and variable types
* Missing data analysis and targeted imputation
* Outlier detection and handling
* Feature engineering
* Recursive feature selection
* Stratified train-test splitting
* Model training and evaluation
* Model interpretation using SHAP

Each step is presented with code, context, and rationale based on pediatric modeling needs. The overall goal is not only to build a working model but also to understand the process behind each modeling choice.

By completing the tutorial, users will learn a replicable approach to predictive modeling in childhood obesity that is consistent with the methodological and ethical guidance presented in the accompanying review paper.

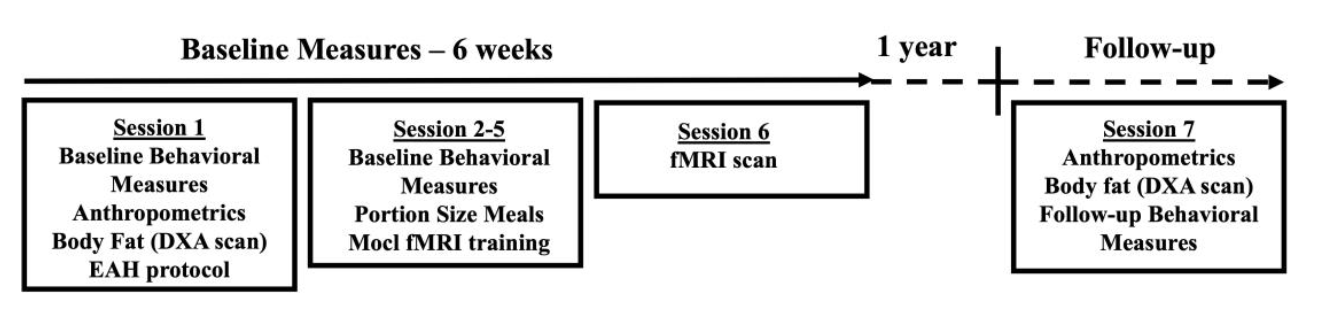
## Step 1: Dataset and Prediction Objective

### 1.1 Dataset Source and Design

The dataset used in this tutorial is a pseudo-synthesized version derived from the Food and Brain Study (NCT02855398). The original study enrolled children aged 7 to 9 years and followed them for approximately one to 1.5 years. The synthesized dataset maintains the structure and variable characteristics of the real study, including repeated meal assessments, psychological evaluations, and caregiver surveys, while protecting participant privacy. **Table 1** gives the predictors we considered for the study.

Key features of the original study design include (see **Figure 1** for timeline):

* Seven study visits (V1 to V7), with baseline data from Visits 1–6 and follow-up data at Visit 7.
* Stratification based on maternal weight status, distinguishing high and low obesity risk groups.
* Behavioral tasks measuring responses to varied portion sizes (100–200%).
* Objective measures of meal intake, eating in the absence of hunger (EAH), and structured caregiver-reported instruments.



**Figure 1.** Study visit timeline for Food and Brain Study

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Table 1. Variables considered for modeling** | | | | |
| **Variable Name in Code** | **Predictor** | **Explanation** |  | |
| Sex (sex\_1: one-hot encoded) | Sex | Biological sex of the child | |  |
| age\_yr | Age | Child’s age at baseline |  | |
| parent\_ed | Parent Education | Highest education level of parent |  | |
| risk\_status\_mom | Maternal BMI Risk Category | Low risk (BMI < 25); high risk (BMI ≥30) | (1) | |
| bmi\_percentile, v7\_bmi\_percentile | Body-Mass Index Percentile | Age- and sex-standardized BMI rank based on population growth references. >95th% = obesity | (2) | |
| v1\_meal\_total\_kcal | Baseline Meal Intake | Calories consumed at baseline meal |  | |
| v1\_eah\_total\_kcal | Baseline EAH Intake | Calories eaten when not hungry | (3–5) | |
| ps\_response\_slope, ps\_response\_int | Portion Size Response | Slope = intake change per gram served; intercept = intake at smallest portion | (6,7) | |
| bite\_size\_slope, bite\_size\_int | Bite Size Response | Slope = g/bite change with portion; intercept = initial bite size | (8–11) | |
| percent\_active\_eating\_slope, percent\_active\_eating\_intercept | Active Eating Time | Slope = % active time change; intercept = % at smallest portion |
| fswitch\_nok\_mean | Food Switching | Average switching between foods during meals | (8,12,13) | |
| mean\_mvpa | Physical Activity (weekly average) | Average time in moderate-to-vigorous physical activity | (14) | |
| mean\_sedentary | Sedentary Activity (weekly average) | Average time spent inactive or sitting |
| avg\_sleep\_frag\_index | Sleep Fragmentation Index | Mean weekly index of sleep interruptions | (15) | |
| cebq\_fr | CEBQ: Food Responsiveness | Eating in response to food cues | (16) | |
| cebq\_avoid | CEBQ: Food Avoidance | Lack of interest in eating or tendency to avoid food |
| cebq\_approach | CEBQ: Food Approach | General interest or enthusiasm for food |
| cebq\_eue | CEBQ: Emotional Overeating | Eating more in response to emotional states |
| cebq\_eue | CEBQ: Emotional Undereating | Eating less in response to emotional states |
| cebq\_dd | CEBQ: Desire to Drink | Frequent requests for drinks, especially sweetened beverages |
| cebq\_se | CEBQ: Satiety Responsiveness | Ability to stop eating when full |
| cebq\_sr | CEBQ: Slowness in Eating | Pace of eating, reflecting low eating speed |
| cebq\_ff | CEBQ: Food Fussiness | Selective eating or rejection of unfamiliar foods |
| cebq\_ef | CEBQ: Enjoyment of Food | General pleasure and interest in food |
| cfq\_pcw | CFQ: Perceived Child Weight | Parental perception of child’s current weight status | (17) | |
| cfq\_cwc | CFQ: Concern About Child Weight | Parental concern about the child becoming overweight |
| cfq\_resp | CFQ: Perceived Responsibility | Parental responsibility over child’s eating |
| cfq\_pressure | CFQ: Pressure to Eat | Parental pressure to eat |
| cfq\_rest | CFQ: Restriction | Restricting child’s eating |
| cfq\_mon | CFQ: Monitoring | Monitoring child’s intake |
| tfeq\_disinhibition | TFEQ: Disinhibition | Overeating tendency | (18) | |
| tfeq\_hunger | TFEQ: Hunger | Perceived hunger |
| tfeq\_cogcontrol | TFEQ: Cognitive Restraint | Conscious intake control |
| pwlb\_healthy | PWLB: Healthy Weight Control Strategy | Use of healthy weight-loss methods | (19) | |
| pwlb\_unhealthy | PWLB: Unhealthy Weight Control Strategy | Use of unhealthy weight-loss methods |
| ffbs\_control | FFBS: Maternal Control | Maternal control over child’s eating | (20) | |
| ffbs\_presence | FFBS: Maternal Presence | Maternal presence during meals |
| ffbs\_ch\_choice | FFBS: Child Choice | Child autonomy in food decisions |
| ffbs\_org | FFBS: Organization | Structure of eating environment |
| brief2\_gec\_p | BRIEF-2: Global Executive Composite | Cognitive self-regulation capacity (Executive Function) | (21) | |
| bas\_drive | BAS Drive | Motivation for goals | (22) | |
| bas\_funseeking | BAS Fun Seeking | Desire for new experiences |
| bas\_rewardresp | BAS Reward Responsiveness | Reward sensitivity |
| bis | BIS | Sensitivity to punishment |
| pds\_score | Pubertal Development Score | Puberty stage assessment | (23) | |
| BMI: Body Mass Index; EAH: Eating in the Absence of Hunger; MVPA: Moderate-to-Vigorous Physical Activity; CEBQ: Children’s Eating Behavior Questionnaire; CFQ: Child Feeding Questionnaire; TFEQ: Three-Factor Eating Questionnaire; PWLB: Parental Weight Loss Behavior; FFBS: Family Food Behavior Survey; BRIEF-2: Behavior Rating Inventory of Executive Function ver2; BIS: Behavioral Inhibition System; **BAS**: Behavioral Activation System | | | | |

### 1.2 Prediction Task

The goal of the ML pipeline is to predict BMI percentile at follow-up (Visit 7) using baseline features collected at Visit 1. This reflects a clinically relevant objective: identifying future obesity risk early enough to inform prevention.

* Prediction type: Supervised regression
* Target variable: v7\_bmi\_percentile
* Input variables: Behavioral, psychological, demographic, caregiver-reported, and anthropometric features from Visit 1

The use of a continuous outcome (BMI percentile) enables modeling risk as a spectrum, avoiding dichotomous labels such as obese vs. not obese. This is particularly applicable in this dataset where most children fall below the obesity threshold but still vary in adiposity risk.

Modeling the change in BMI percentile between the two visits may not be advisable due to the short follow-up period, which results in limited variability in BMI change and can reduce model stability and predictive signal.

### 1.3 Socio-Ecological Framework

Predictors in the dataset reflect two proximal levels of influence:

* *Child-level*: physical activity, eating behavior, psychological traits
* *Family-level*: caregiver perception, feeding styles, home food environment

These domains align with socio-ecological models of childhood obesity and capture modifiable influences that may precede changes in weight status. See **Figure 2** for the variety of metrics collected across the Food and Brain Study.

A diagram of a study measures

AI-generated content may be incorrect.

**Figure 2**. Metrics collected in Food and Brain study

### 1.4 Why This Dataset Is Useful for ML Training

This dataset includes several properties that make it useful for ML tutorial purposes:

* *Behavioral richness:* multiple eating behavior measures are included, often overlooked in ML studies.
* *Structured missingness:* realistic missing data patterns offer hands-on experience with imputation.
* *Variable diversity:* both continuous and categorical predictors spanning psychosocial, behavioral, and physiological domains.
* *Moderate sample size:* approximately 300 cases, typical of child cohort studies, useful for discussing model complexity vs. overfitting.

This setup enables illustration of practical modeling challenges such as structured missing data, collinearity, feature selection, and interpretation in developmentally sensitive datasets.

## Step 2: Feature Engineering

### 2.1 Why Feature Engineering Is Critical in Pediatric Datasets

Feature engineering transforms raw variables into structured, informative inputs that better capture behavioral and developmental patterns. In pediatric obesity research, this process must account for the developmental context, age-related differences in behavior, and non-linear relationships that are common in caregiver-reported or task-derived variables.

Many features in this dataset were not directly used in their raw form but were transformed to reflect response patterns, temporal scaling, or age-adjusted relevance. Unlike standard demographic features, behavioral metrics often require derived representations to align with their theoretical meaning (e.g., slope of portion response, bite rate, active eating profiles).

### 2.2 Behavioral Response Slopes and Intercepts

Several features were engineered by modeling a child’s response across increasing portion sizes:

* **Bite size slope**: Rate of change in bite size as portion increases, computed as grams consumed per number of bites at each portion size level.
* **Percent active eating slope**: Change in the ratio of active eating time to total meal duration across portion sizes.
* **Intercepts**: Represented baseline behavior at the smallest portion size (100%).
* **Food switching**: Averaged across all four portion size conditions to reflect typical behavior.
* **Bite rate**: Calculated as the average number of bites per minute across the four portion sizes.

Slopes were derived using linear regression across the 100%, 133%, 167%, and 200% portion size conditions. These slopes capture reactivity to portion size increases, while intercepts indicate baseline tendencies.

### 2.3 Wear-Time Adjusted Averages for Activity and Sleep

Actigraphy-derived features were calculated only for children with sufficient wear time:

* Data were included if the child had at least **3 valid days** of wear data
* A day was considered valid if **wear time ≥ 600 minutes (10 hours)**

From these criteria, the following weekly averages were computed:

* **Mean MVPA**: Average minutes per day in moderate-to-vigorous physical activity
* **Mean sedentary time**: Average minutes per day spent inactive or sitting
* **Average sleep fragmentation index**: Mean of the nightly fragmentation scores across valid days

These thresholds follow established practices in pediatric actigraphy research and help ensure that derived features reflect typical behavior rather than sporadic or non-compliant tracking.

### 2.4 Age-Sensitive Adjustments

While most children in the cohort were of similar age (7–9 years), small variations in age or pubertal status can influence behavioral and cognitive measures. Some psychometric tools were interpreted with age-standardized scores (e.g., BRIEF-2), and sensitivity analyses were conducted to assess whether inclusion of raw age or pubertal score improved prediction.

Age was also included as a covariate in later modeling stages and considered when assessing whether engineered features were developmentally plausible (e.g., extreme bite rates in older vs. younger children). Refer back to **Table 1** for features and corresponding feature engineering.

These engineered features were added to the working dataset and used in both exploratory and model training phases.

Feature engineering decisions were guided by existing literature on child eating behaviors and domain expert input. Emphasis was placed on maintaining interpretability and aligning with theoretical constructs of appetite, responsiveness, satiety regulation, and movement behaviors in middle childhood.

## Step 3: Data Splitting: Train and Test Split

Before model feature selection and model training, we performed a **stratified train-test split** based on sex to ensure proportional representation of male and female participants in both sets. This is important in pediatric data given potential sex-related differences in growth trajectories, behavioral patterns, and BMI percentile distributions.

* **Split ratio**: 80% train, 20% test
* **Stratification variable**: sex
* **Random seed**: 42 (for reproducibility for split datasets)
* **Leakage prevention**: All feature selection, hyperparameter tuning, and imputation were performed **within** the training set only. The test set was held out and untouched until final model evaluation.

This procedure ensures an unbiased estimate of model performance and guards against information leakage across data partitions, especially when done before feature selection.

## Step 4: Missing Data Analysis

### 4.1 Rationale

Missing data are a routine and often underestimated challenge in pediatric health datasets, especially when using behavioral or caregiver-reported features. In this tutorial, we begin with a structured approach to diagnosing missingness across all variables before applying appropriate imputation strategies. Understanding the extent and pattern of missingness is essential for minimizing bias and preserving the generalizability of predictive models.

### 4.2 Diagnostic Steps

We followed a multi-step diagnostic process:

* Calculated the proportion of missing data for each feature.
* Categorized features based on missingness levels (e.g., low <5%, moderate 5–15%, high >15%).
* Generated a bar plot of missingness percentage across features.
* Created a missingness heatmap to assess patterns across cases and features.

These steps enabled preliminary identification of features that may be missing completely at random (MCAR), at random (MAR), or not at random (MNAR).

### 4.3 Observed Patterns

* Most features had low (<5%) to moderate (5–15%) missingness.
* Some key variables, including avg\_sleep\_frag\_index, had >40% missingness, raising concerns about data reliability and potential exclusion.
* Behavioral and psychological measures showed clustered missingness within certain cases, consistent with incomplete survey responses.

These patterns suggest a combination of MCAR and MAR mechanisms, warranting variable-specific imputation strategies (see **Table 2** and **Figure 3**).

|  |  |  |  |
| --- | --- | --- | --- |
| **Table 2.** Missingness Summary | | |  |
| **Feature** | **Missing Count** | **Missing %** | Strategy to address missingness |
| avg\_sleep\_frag\_index | 137 | 49.82 | Excluded for modeling |
| brief2\_gec\_p | 46 | 16.73 | kNN impute |
| mean\_mvpa | 33 | 12.00 | kNN impute |
| mean\_sedentary | 33 | 12.00 | kNN impute |
| tfeq\_hunger | 17 | 6.18 | kNN impute |
| tfeq\_cogcontrol | 13 | 4.73 | kNN impute |
| cebq\_approach | 10 | 3.64 | median impute |
| cebq\_eoe | 10 | 3.64 | median impute |
| cebq\_avoid | 9 | 3.27 | mode impute |
| tfeq\_disinhibition | 8 | 2.91 | median impute |
| income | 7 | 2.55 | median impute |
| cfq\_pcw | 6 | 2.18 | median impute |
| cfq\_cwc | 6 | 2.18 | median impute |
| bis | 6 | 2.18 | median impute |
| cebq\_ff | 5 | 1.82 | median impute |
| v1\_eah\_total\_kcal | 5 | 1.82 | median impute |
| cebq\_se | 4 | 1.45 | median impute |
| cebq\_eue | 4 | 1.45 | median impute |
| v1\_meal\_total\_kcal | 3 | 1.09 | median impute |
| pwlb\_healthy | 1 | 0.36 | median impute |
| fswitch\_nok\_mean | 1 | 0.36 | median impute |
| bite\_size\_int | 1 | 0.36 | median impute |
| bite\_size\_slope | 1 | 0.36 | median impute |

A purple and yellow chart

AI-generated content may be incorrect. A graph of a number of data

AI-generated content may be incorrect.

**Figure 3:** Missingness in variables of train dataset

### 4.4 Strategy and Justification

Based on the diagnostic results, our imputation strategy was tiered by feature type and missingness level (see **Table 2**):

* **Low missingness (<5%)**: median or mode imputation, depending on variable type.
* **Moderate missingness (5–15%)**: K-nearest neighbors (KNN) imputation for continuous variables.
* **High missingness (>30%)**: flagged for review; some were excluded due to unreliability of imputation.

This approach balances model performance, transparency, and developmental plausibility. It is particularly suitable for pediatric datasets where blanket strategies (e.g., listwise deletion or mean imputation) can bias results or exclude meaningful behavioral data. The strategy was based on training data missingness.

Each decision was grounded in theory and practicality, reinforcing the principle that preprocessing steps should be informed by both statistical logic and domain-specific understanding of the data.

## Step 5: Outlier Detection and Handling

### 5.1 Why Outlier Handling Matters in Pediatric Data

In pediatric datasets, outliers can arise from measurement error, data entry mistakes, or genuine but rare behaviors. Due to small-to-moderate sample sizes and age-sensitive variability in behavior and physiology, even a few extreme values can disproportionately affect model estimates. Therefore, outlier detection and mitigation are important for maintaining stability and interpretability in downstream ML models.

Unlike in large epidemiological datasets, pediatric studies often rely on proxy reports, structured tasks, and small sample-derived behavioral metrics (e.g., bite size slope, meal duration). These measures can show high variability and may not conform to population-based expectations. As such, identifying and managing outliers requires both distributional checks and domain understanding.

### 5.2 Visual Inspection as First-Line Tool

We used boxplots (**Figure 4**) to visually inspect the distribution of all continuous features, in training set. This approach allowed us to:

* Identify extreme values outside the whisker range (1.5 × IQR)
* Detect skewness that may not be biologically plausible
* Flag values that deviate markedly from the central tendency

Variables related to caloric intake, bite size, and physical activity (e.g., mean\_mvpa, v1\_meal\_total\_kcal, bite\_size\_slope) showed visible extreme values. These outliers may reflect true variability, measurement artifacts, or device wear-time issues (e.g., accelerometer compliance).

In contrast, most psychometric and questionnaire-derived scores (e.g., CEBQ, CFQ subscales) exhibited minimal outliers, likely due to bounded response scales and standardized instruments.

A chart with blue squares

AI-generated content may be incorrect.

**Figure 4.** Boxplots of variables (continuous variables) to understand outliers (train set)

### 5.3 Winsorization Strategy

To manage outliers without excluding valuable data, we applied winsorization on training data (same strategy applied to test data):

* Values below the 1st percentile and above the 99th percentile were capped at those percentile thresholds
* This was applied only to selected variables with high skew and outlier influence

Winsorization is appropriate in pediatric behavioral datasets where extreme values may arise from noise rather than signal. It preserves sample size while reducing the undue influence of extreme points on model training. We avoided listwise deletion to prevent loss of rare but meaningful cases.

|  |  |  |
| --- | --- | --- |
| **Table 3. Outlier addressing Strategy** | | |
| **Variable Category** | **Typical Outlier Presence** | **Action Taken** |
| Physical activity (mean\_mvpa) | Right-skewed distribution | Winsorized at 1st and 99th percentiles |
| Eating behavior slopes | Bi-directional outliers (both tails) | Winsorized at 1st and 99th percentiles |
| Caloric intake (meal or EAH kcal) | Extreme high values | Winsorized at 1st and 99th percentiles |
| Questionnaire-based scales | Minimal outliers | Retained without modification |

This approach ensured that the dataset remained robust against modeling distortion while preserving underlying behavioral signal.

Outlier handling decisions were based not only on statistical thresholds but also on whether values were developmentally implausible or inconsistent with measurement protocols. The balance of domain knowledge and visual diagnostics guided our choices.

Sex column was also one-hot encoded to make it suitable for training.

## Step 6: Feature Selection

### 6.1 Necessity of Feature Selection

Feature selection reduces dimensionality, improves model interpretability, and decreases the risk of overfitting especially important in pediatric datasets that often have small sample sizes and highly correlated behavioral variables. Many predictors in childhood obesity research are theoretically relevant but statistically redundant. Without proper selection, models risk learning noise rather than signal.

In this dataset, feature selection was especially important because of the overlap across multiple domains including behavioral slopes, caregiver reports, activity metrics, and psychological assessments. Many variables may individually show weak associations with the outcome but contribute meaningfully through interactions. Univariate filtering alone would be insufficient.

### 6.2 Stepwise Selection Strategy

We implemented a two-stage process for identifying the most predictive features.

**Stage 1: Correlation Screening** We began with univariate correlation analysis to identify predictors with zero or minimal relationship to the outcome (v7\_bmi\_percentile). While not used for formal selection, this helped deprioritize clearly uninformative variables (see **Figure 5**). As expected, baseline BMI percentile showed the strongest correlation (r = 0.92), while most other features demonstrated weak or negligible linear associations, reinforcing the need for multivariate, model-based selection approaches.

**Stage 2: RFE-CV + Nested Cross-Validation** We then conducted model-dependent selection using Recursive Feature Elimination with Cross-Validation (RFE-CV), nested within an outer cross-validation loop. This allowed joint optimization of both the feature subset and the model hyperparameters. Each outer fold used the best-performing feature count and configuration from the inner CV.

This approach allowed the algorithm to:

* Reduce variance in feature selection
* Tune model complexity in alignment with predictor strength
* Avoid information leakage between tuning and evaluation phases

A screenshot of a computer

AI-generated content may be incorrect.

**Figure 5.** Univariate Correlations with outcome (follow-up BMI%)

### 6.3 Why RFE-CV vs Standard RFE?

Unlike standard RFE, which evaluates features on a single data split, **RFE-CV** ranks features based on cross-validated model performance. This reduces the likelihood of selecting predictors that perform well only by chance or within a specific fold. The nesting structure further allowed feature selection and hyperparameter tuning to be optimized jointly.

* **Inner loop**: Used RFE-CV to identify the most predictive subset of features within each fold.
* **Outer loop**: Evaluated model performance across a range of hyperparameter settings using the selected features.

This approach helped:

* Identify stable predictors that generalize across folds
* Avoid bias from tuning on the same data used for selection
* Capture interdependencies between model structure and feature informativeness

### 6.4 Summary of Feature Selection Results

Using nested cross-validation combining Recursive Feature Elimination with Cross-Validation (RFE-CV) and joint hyperparameter tuning, we identified distinct predictive subsets under two modeling scenarios: with and without baseline BMI percentile.

**With Baseline BMI Percentile**

Models using bmi\_percentile as a baseline predictor continued to perform competitively, with the lowest outer MAE of 3.74 observed in Fold 3. This feature was consistently selected across all folds, reinforcing its utility as a stable single-variable predictor. In Fold 2, the addition of mean\_mvpa and mean\_sedentary marginally improved performance, indicating potential added value from physical activity measures. However, across folds, inner cross-validation curves showed noisy behavior, with no consistent benefit beyond a small number of features. These patterns support the use of a compact model, with diminishing returns after including 1 to 3 features.

**Without Baseline BMI Percentile**

Excluding baseline BMI percentile led to higher prediction error, with the best outer fold MAE reaching 8.16. Models required a broader set of features—typically 15 to 24—to compensate for the absence of direct adiposity indicators. Physical activity (mean\_mvpa, mean\_sedentary), executive functioning (brief2\_gec\_p), eating behavior traits (tfeq\_disinhibition), and parental feeding practices (cfq\_pcw, cfq\_cwc, cfq\_pressure) appeared frequently across folds. The variability in selected features suggests that predictive signals were more diffuse without a baseline anthropometric anchor, reinforcing the central role of BMI percentile in efficient short-term prediction. Nonetheless, consistent inclusion of several behavioral and cognitive variables highlights their complementary value. These results indicate that while baseline BMI percentile drives predictive accuracy, the feature selection process without it highlights a broader set of behavioral and caregiver-report variables relevant to early risk profiling.

## 7. Model Training

After completing feature and hyperparameter selection in the previous section, final models were trained using the selected features and corresponding optimal configurations. All training was conducted on the full training set, using only features and parameters identified through nested cross-validation to avoid information leakage and overfitting.

### 7.1 Separate Training Pipelines

To address different prediction goals and interpretability needs in pediatric obesity research, three distinct modeling pipelines were implemented:

1. **BMI-Based Model:** Included baseline BMI percentile
   * **Hypothesis:** Baseline BMI is the strongest available predictor of short-term weight status.
   * **Utility:** Optimized for **clinical risk tracking** in children already presenting with elevated or at-risk BMI. This model prioritizes predictive accuracy and is well-suited for near-term forecasting in clinical settings.
2. **Behavioral-Only Model:** Excluded baseline BMI percentile
   * **Hypothesis:** Modifiable behavioral, psychological, and environmental predictors alone can provide signal for early obesity risk, even without current BMI status.
   * **Utility:** Designed for **early identification and prevention**, particularly in children not yet exhibiting excess weight but potentially on a higher-risk trajectory based on their behavioral profiles. This model emphasizes **intervention-relevant features**.

Each scenario was treated independently throughout model development. Separate pipelines ensured that the training process, including feature selection and parameter tuning, was appropriately tailored to each model’s structure and intended use case. This allowed for a fair comparison of model performance under different assumptions about available data and intervention goals.

## 8. Model Evaluation and Feature Evaluation

### 8.1 Model Evaluation Metrics

## MAE (Mean Absolute Error)

## RMSE (Root Mean Squared Error)

## R² (Coefficient of Determination)

### 8.2 Performance Results

Table 4presents evaluation of the three models on test set.

|  |  |  |  |
| --- | --- | --- | --- |
| **Table 4. Model evaluation** | | | |
| **Model Type** | **MAE** | **RMSE** | **R²** |
| BMI-Based Model | 3.01 | 4.37 | 0.91 |
| Behavioral-Only Model | 6.82 | 10.40 | 0.48 |

### 8.3 Interpretation and Practical Utility

1. **BMI-Based Model** demonstrated the highest predictive performance across all metrics, with an R² of 0.89 and the lowest error rates (MAE = 3.01, RMSE = 4.37, R2 = 0.91). This is expected due to the inclusion of baseline BMI percentile, which is a strong statistical predictor of future BMI percentile.

**Practical utility**:

* + This model is well-suited for **clinical triage and risk stratification**, especially in settings where prior growth data is readily available.
  + It can be used to identify children at elevated risk for continued or worsening obesity, guiding early intervention decisions.
  + However, its heavy reliance on a single dominant predictor limits interpretability regarding why risk is elevated, which may be a barrier in family-centered care or behavioral counseling contexts.

1. **Behavioral-Only Model** produced substantially lower predictive accuracy (R² = 0.48), with wider prediction errors (MAE = 6.82, RMSE = 10.40). Despite this, it surfaced key behavioral features such as food responsiveness, bite rate, and active eating duration, which contributed meaningfully to variance explained.

**Practical utility**:

* + This model is most appropriate in settings where **baseline BMI data are unavailable or unreliable**, such as in mobile health tools, screening during community outreach, or retrospective risk assessment using behavioral surveys.
  + It may also serve as a **hypothesis-generating tool** for identifying behavioral phenotypes or informing the design of targeted behavioral interventions.
  + While not accurate enough for clinical prediction alone, it provides insight into potentially modifiable risk pathways that can be the focus of family-based education or coaching.

### 8.4 SHAP-Based Model Interpretation

To examine how individual features contributed to predictions, we used SHAP (SHapley Additive exPlanations), which assigns each prediction a set of feature attributions based on their marginal impact.

For each model, we generated plots for **SHAP analysis for model with BMI% (Figure 7) and model without BMI% (Figure 8).**

* The **bar plot** summarizes the average absolute contribution of each feature to model predictions across all participants.
* The **beeswarm plot** visualizes the full distribution of SHAP values per feature, with each point representing an individual observation. Point color reflects the original feature value (red = high, blue = low), and horizontal position indicates the direction and strength of the feature’s impact.

These plots are useful for identifying both **overall feature importance** and **how individual-level variation in predictors affects predictions**, which is particularly valuable in pediatric models where behavioral patterns and clinical indicators often vary substantially between individuals.

**Clinical and Research Utility**

* SHAP beeswarm plots offer **individual-level transparency** in how the model generates predictions.
* They enable **personalized explanation** of risk, which can support:
  + Tailored family feedback
  + Targeted behavioral interventions
  + Clinician confidence in model outputs
* These interpretations also support **mechanistic understanding** in research, informing future hypothesis testing or feature design.

### 1. BMI-Based Model

**Top Features**

* bmi\_percentile
* mean\_mvpa
* mean\_sedentary

**Interpretation**

* bmi\_percentile: As expected, this was the most influential feature. Higher baseline BMI percentiles consistently predicted higher future values.
* mean\_mvpa: More physical activity was modestly protective but secondary to baseline BMI.
* mean\_sedentary: Higher sedentary time was associated with higher predicted BMI percentile, suggesting that physical inactivity contributes independently.

**Conceptual Context**  
This model reflects BMI continuity and mirrors current clinical practice in which BMI trajectories are used for risk assessment.

**Clinical Relevance**  
This model showed the highest accuracy and is intuitive for monitoring growth trends. However, it does not explain behavioral mechanisms or support behaviorally targeted interventions.

### 2. Behavioral-Only Model

**Top Features**

* mean\_mvpa
* mean\_sedentary
* tfeq\_cogcontrol
* cfq\_cwc
* percent\_active\_eating\_slope

**Interpretation**

* mean\_mvpa: Higher MVPA values were linked to lower predicted BMI.
* mean\_sedentary: Higher sedentary behavior contributed positively to predicted BMI.
* tfeq\_cogcontrol and cfq\_cwc: SHAP distributions showed heterogeneity, indicating that the impact of parental control and concern varies across individuals.
* percent\_active\_eating\_slope: A steeper slope was associated with higher BMI risk, consistent with food approach behaviors.

**Conceptual Context**  
This model isolates behavior-based and psychological drivers of risk, offering insight into obesity risk independently of baseline anthropometrics.

**Clinical Relevance**  
Though less predictive overall, this model is useful for counseling and prevention, particularly in the absence of growth data. It supports early identification of risk through modifiable behaviors and family dynamics.

**A**

**A graph with blue and red text

AI-generated content may be incorrect.**

**B**

**Figure 7.**  **SHAP summary plots for the BMI-based model predicting future BMI percentile.**

**The upper panel displays the mean absolute SHAP values, showing that baseline bmi\_percentile had the greatest influence on model predictions, followed by mean\_mvpa and mean\_sedentary. The lower panel is a beeswarm plot, with each point representing a participant. Point color indicates the original feature value (blue = low, red = high), and horizontal position reflects the SHAP value, indicating direction and strength of impact. Higher baseline BMI strongly increased predicted BMI percentile. Higher physical activity generally decreased predicted values, while higher sedentary time contributed modestly to increased predictions.**

A close-up of a graph

AI-generated content may be incorrect.

**Figure 8. SHAP summary plots for the behavioral-only model predicting BMI percentile.**  
Panel A shows the mean absolute SHAP values for each predictor, indicating overall feature importance across all participants. mean\_mvpa (moderate-to-vigorous physical activity) and mean\_sedentary (sedentary time) were the most influential features. Panel B displays the SHAP beeswarm plot, where each point represents an individual prediction. Point position reflects the SHAP value (feature impact on model output), and color indicates the original feature value (blue = low, red = high). Higher physical activity generally reduced predicted BMI percentile, while higher sedentary time increased it. Several cognitive and family-based variables also showed heterogeneous contributions, suggesting individual-level variation in behavioral risk pathways.

**Summary Comparison:**

| **Table 5. Summary of Model Performance** | | | |
| --- | --- | --- | --- |
| **Model** | **Strengths** | **Clinical Use Case** | **Limitations** |
| **Behavioral-Only** | Captures modifiable risk; aligns with behavioral theory | Prevention, behavior change, research trials | Lower predictive accuracy |
| **BMI-Based** | High accuracy; trajectory-based prediction | Growth screening, EMR use | Lacks behavioral interpretability and no possible intervention |

A comparison of a graph

AI-generated content may be incorrect.

**Figure 9.** **Predicted versus actual BMI percentiles at follow-up for two models.**

**Panel A shows prediction accuracy for the behavioral-only model, which excludes baseline BMI percentile. Panel B shows accuracy for the BMI-based model that includes baseline BMI as a predictor. Each point represents one participant, with the red dashed line indicating perfect prediction (red line). The behavioral model (A) shows greater dispersion and underestimation at higher percentiles, indicating lower predictive accuracy. The BMI-based model (B) closely tracks the diagonal, reflecting higher accuracy driven by the strong influence of prior BMI percentile.**

### 8.5 Prediction Accuracy

**Prediction vs. Actual BMI Percentile (Figure 9):**  
The BMI-based model showed close clustering around the identity line, indicating strong agreement between predicted and actual BMI percentiles. In contrast, the behavioral-only model exhibited greater dispersion, particularly at the lower and upper ends of the BMI percentile range, reflecting reduced predictive accuracy in children at the extremes.

## Step 9: Conclusion and Discussion

### 9.1 Summary of Key Findings

This tutorial demonstrated the application of machine learning models to predict follow-up BMI percentile in a pediatric cohort using behavioral, psychological, and anthropometric data. We trained and evaluated three models:

* A high-performing BMI-Based Model driven largely by baseline BMI percentile
* A behaviorally focused model that emphasized interpretability but had lower predictive strength

Feature selection and hyperparameter tuning were conducted jointly to reflect the interdependence of variable importance and model structure. SHAP analysis provided insight into feature contributions and supported model transparency.

### 9.2 Interpretation and Use Cases

* The **BMI-Based Model** is best suited for clinical scenarios where baseline BMI is routinely available. Its high accuracy makes it ideal for tracking risk over short-term follow-up.
* The **Behavioral-Only Model** provides insight into modifiable factors that may drive future weight gain. It may be appropriate in community or early intervention contexts where prior anthropometric data are unavailable.

### 9.3 Cautions and Limitations

Several limitations should be acknowledged:

* **Short follow-up period**: Limits the variability in BMI change, reducing the signal for true behavioral predictors.
* **Sample size**: As is common in pediatric research, the moderate sample size constrains model complexity and may reduce generalizability.
* **Proxy-reported and task-derived data**: While ecologically valid, these variables may have inconsistent reliability across children and require cautious interpretation.
* **Synthetic dataset**: Although modeled after real data, the tutorial used a de-identified synthetic dataset. Performance on real clinical data may differ.

Models that include baseline BMI risk overstating their performance due to autocorrelation. Researchers must be cautious when interpreting models dominated by anthropometric history, particularly if the goal is to uncover modifiable predictors.

### 9.4 Broader Implications

This tutorial highlights the need for pediatric ML pipelines that integrate:

* Domain knowledge in feature engineering
* Rigorous preprocessing for missingness and outliers
* Joint consideration of interpretability and accuracy
* Transparent model interpretation using tools like SHAP

Future work should explore longer-term prediction, external validation, and integration of additional contextual variables such as food environment, social dynamics, or digital phenotyping.

In conclusion, ML can enhance our understanding of childhood obesity risk, but its application must be developmentally grounded, ethically cautious, and interpreted in partnership with pediatric and behavioral experts.

**REFERENCES**

1. Oken E. Maternal and child obesity: the causal link. Obstetrics and Gynecology Clinics. 2009;36(2):361–77.

2. Kuczmarski RJ, Ogden CL, Guo SS, Grummer-Strawn LM, Flegal KM, Mei Z, et al. 2000 CDC Growth Charts for the United States: methods and development. Vital Health Stat 11. 2002 May;(246):1–190.

3. Bhat YR, Rolls BJ, Wilson SJ, Rose E, Geier CF, Fuchs B, et al. Eating in the Absence of Hunger Is a Stable Predictor of Adiposity Gains in Middle Childhood. The Journal of Nutrition. 2024 Dec 1;154(12):3726–39. https://doi.org/10.1016/j.tjnut.2024.10.008

4. Fisher JO, Birch LL. Eating in the absence of hunger and overweight in girls from 5 to 7 y of age. The American journal of clinical nutrition. 2002;76(1):226–31.

5. Fogel A, McCrickerd K, Fries LR, Goh AT, Quah PL, Chan MJ, et al. Eating in the absence of hunger: Stability over time and associations with eating behaviours and body composition in children. Physiol Behav. 2018 Aug 1;192:82–9. https://doi.org/10.1016/j.physbeh.2018.03.033

6. Rolls BJ, Engell D, Birch LL. Serving portion size influences 5-year-old but not 3-year-old children’s food intakes. Journal of the Academy of Nutrition and Dietetics. 2000;100(2):232.

7. Young LR, Nestle M. The Contribution of Expanding Portion Sizes to the US Obesity Epidemic. Am J Public Health. 2002 Feb;92(2):246–9.

8. Pearce AL, Evens J, Romano O, Keller KL. Food and Brain Study - Observational Coding Manual. 2023 Jul 12; https://doi.org/10.5281/zenodo.8140896

9. Fogel A, Goh AT, Fries LR, Sadananthan SA, Velan SS, Michael N, et al. A description of an ‘obesogenic’eating style that promotes higher energy intake and is associated with greater adiposity in 4.5 year-old children: Results from the GUSTO cohort. Physiology & behavior. 2017;176:107–16.

10. Pearce AL, Cevallos MC, Romano O, Daoud E, Keller KL. Child Meal Microstructure and Eating Behaviors: A Systematic Review. Appetite. 2022 Jan 1;168:105752. https://doi.org/10.1016/j.appet.2021.105752

11. Pearce AL, Neuwald NV, Evans JS, Romano O, Rolls BJ, Keller KL. Child eating behaviors are consistently linked to intake across meals that vary in portion size. Appetite. 2024 May 1;196:107258. https://doi.org/10.1016/j.appet.2024.107258

12. Neuwald NV, Pearce AL, Cunningham PM, Setzenfand MN, Koczwara L, Rolls BJ, et al. Food switching at a meal is positively associated with change in adiposity among children at high-familial risk for obesity. Appetite. 2025 Apr 1;208:107915. https://doi.org/10.1016/j.appet.2025.107915

13. Neuwald NV, Pearce AL, Adise S, Rolls BJ, Keller KL. Switching between foods: A potential behavioral phenotype of hedonic hunger and increased obesity risk in children. Physiol Behav. 2023 Oct 15;270:114312. https://doi.org/10.1016/j.physbeh.2023.114312

14. Evenson KR, Catellier DJ, Gill K, Ondrak KS, McMurray RG. Calibration of two objective measures of physical activity for children. J Sports Sci. 2008 Dec;26(14):1557–65. https://doi.org/10.1080/02640410802334196

15. Zuraikat FM, Bauman JM, Setzenfand MN, Arukwe DU, Rolls BJ, Keller KL. Dimensions of sleep quality are related to objectively measured eating behaviors among children at high familial risk for obesity. Obesity (Silver Spring). 2023 May;31(5):1216–26. https://doi.org/10.1002/oby.23754

16. Wardle J, Guthrie CA, Sanderson S, Rapoport L. Development of the Children’s Eating Behaviour Questionnaire. J Child Psychol Psychiatry. 2001 Oct;42(7):963–70. https://doi.org/10.1111/1469-7610.00792

17. Birch LL, Fisher JO, Grimm-Thomas K, Markey CN, Sawyer R, Johnson SL. Confirmatory factor analysis of the Child Feeding Questionnaire: a measure of parental attitudes, beliefs and practices about child feeding and obesity proneness. Appetite. 2001 Jun 1;36(3):201–10. https://doi.org/10.1006/appe.2001.0398

18. Stunkard AJ, Messick S. The three-factor eating questionnaire to measure dietary restraint, disinhibition and hunger. J Psychosom Res. 1985;29(1):71–83. https://doi.org/10.1016/0022-3999(85)90010-8

19. Wardle J, Sanderson S, Guthrie CA, Rapoport L, Plomin R. Parental feeding style and the inter-generational transmission of obesity risk. Obes Res. 2002 Jun;10(6):453–62. https://doi.org/10.1038/oby.2002.63

20. McCurdy K, Gorman KS. Measuring family food environments in diverse families with young children. Appetite. 2010 Jun;54(3):615–8. https://doi.org/10.1016/j.appet.2010.03.004

21. Gioia GA, Guy SC, Kenworthy L. Behavior rating inventory of executive function. Child Neuropsychology. 2000;

22. Carver CS, White TL. Behavioral inhibition, behavioral activation, and affective responses to impending reward and punishment: the BIS/BAS scales. Journal of personality and social psychology. 1994;67(2):319.

23. Petersen AC, Crockett L, Richards M, Boxer A. Pubertal Development Scale (PDS). 1988. https://doi.org/10.1037/t06349-000